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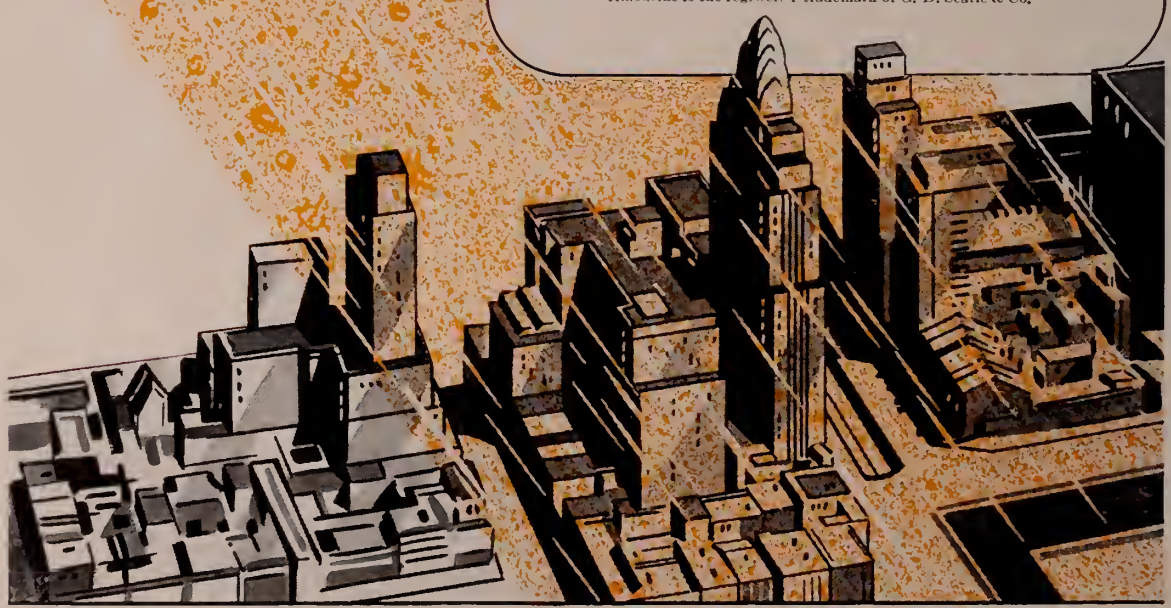
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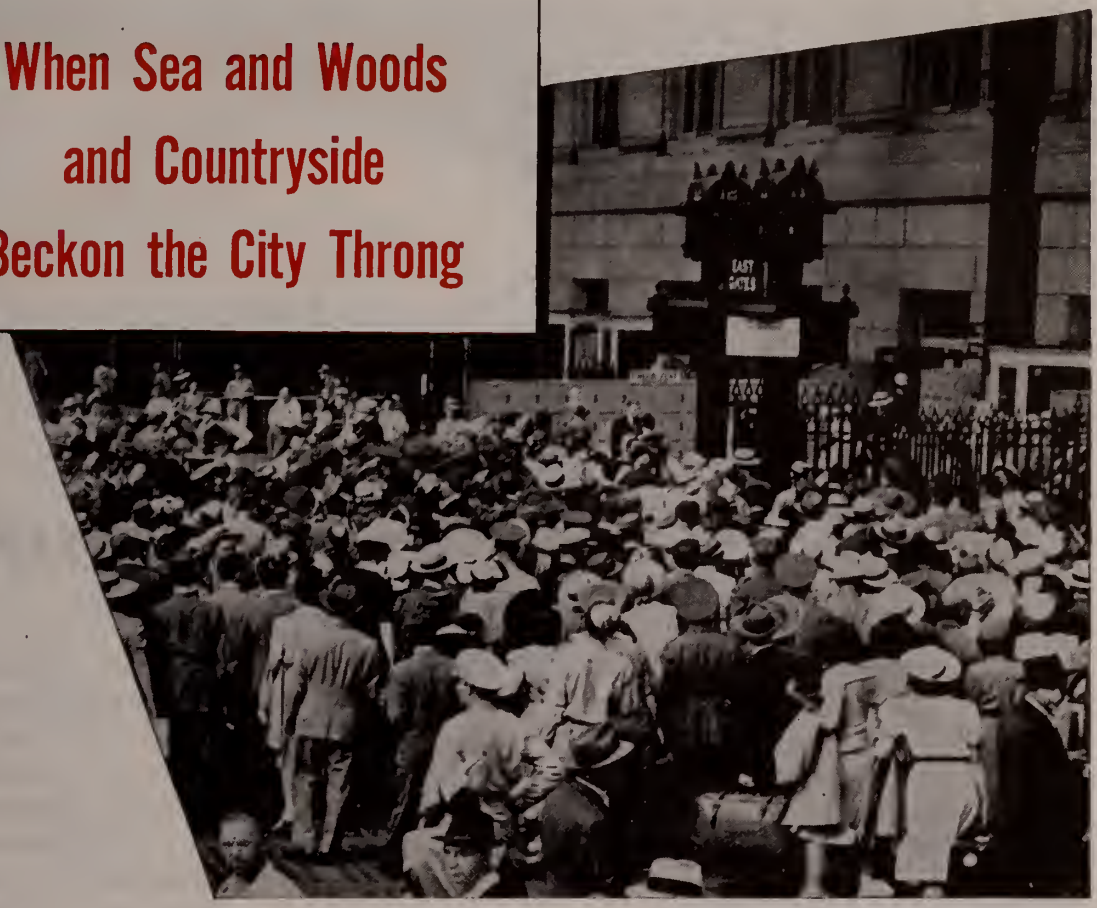


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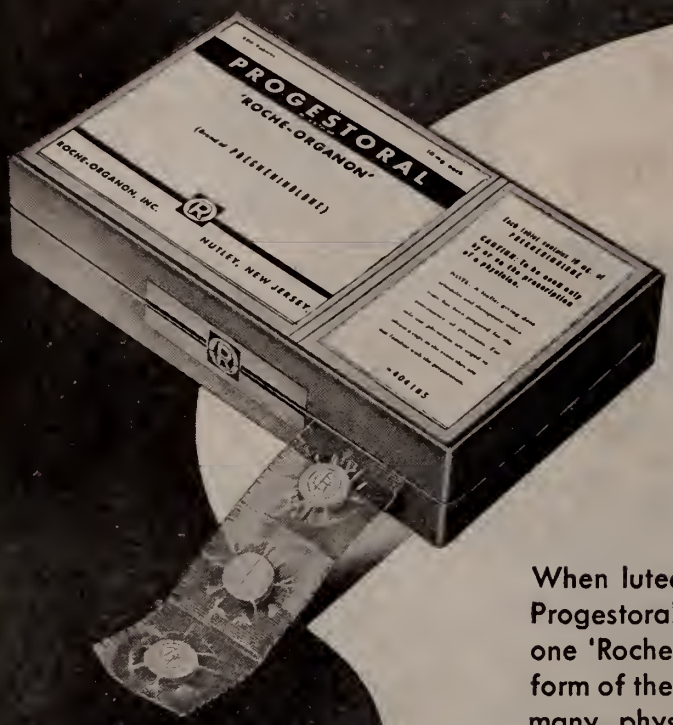
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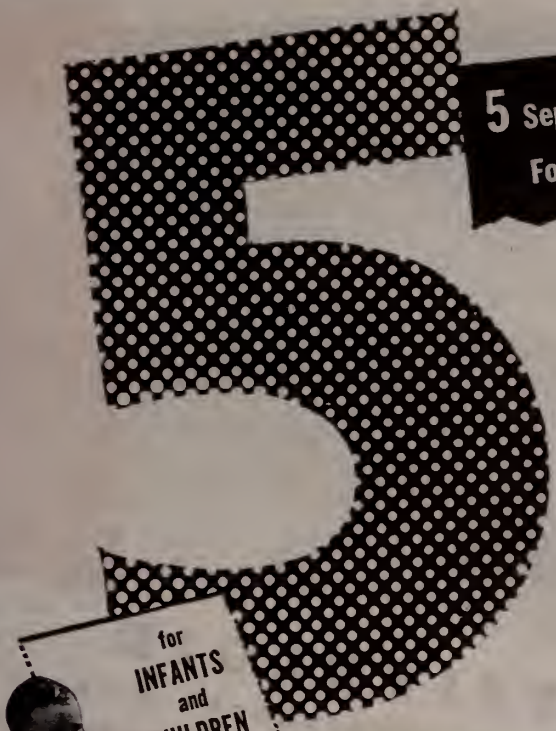
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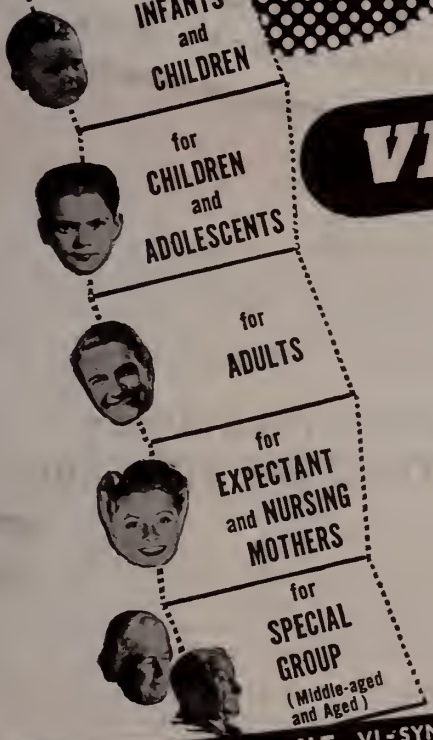
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*J. K. Quigley, Am. J. Obst. & Gynec., 49:633, 1945



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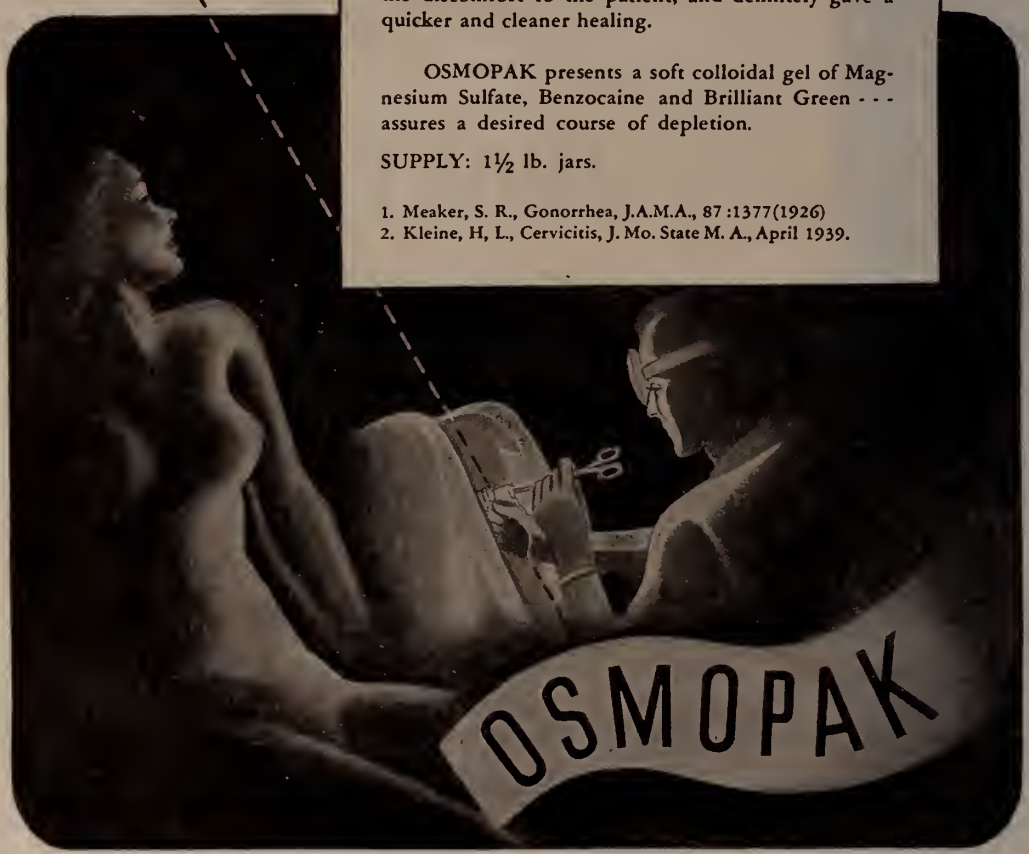
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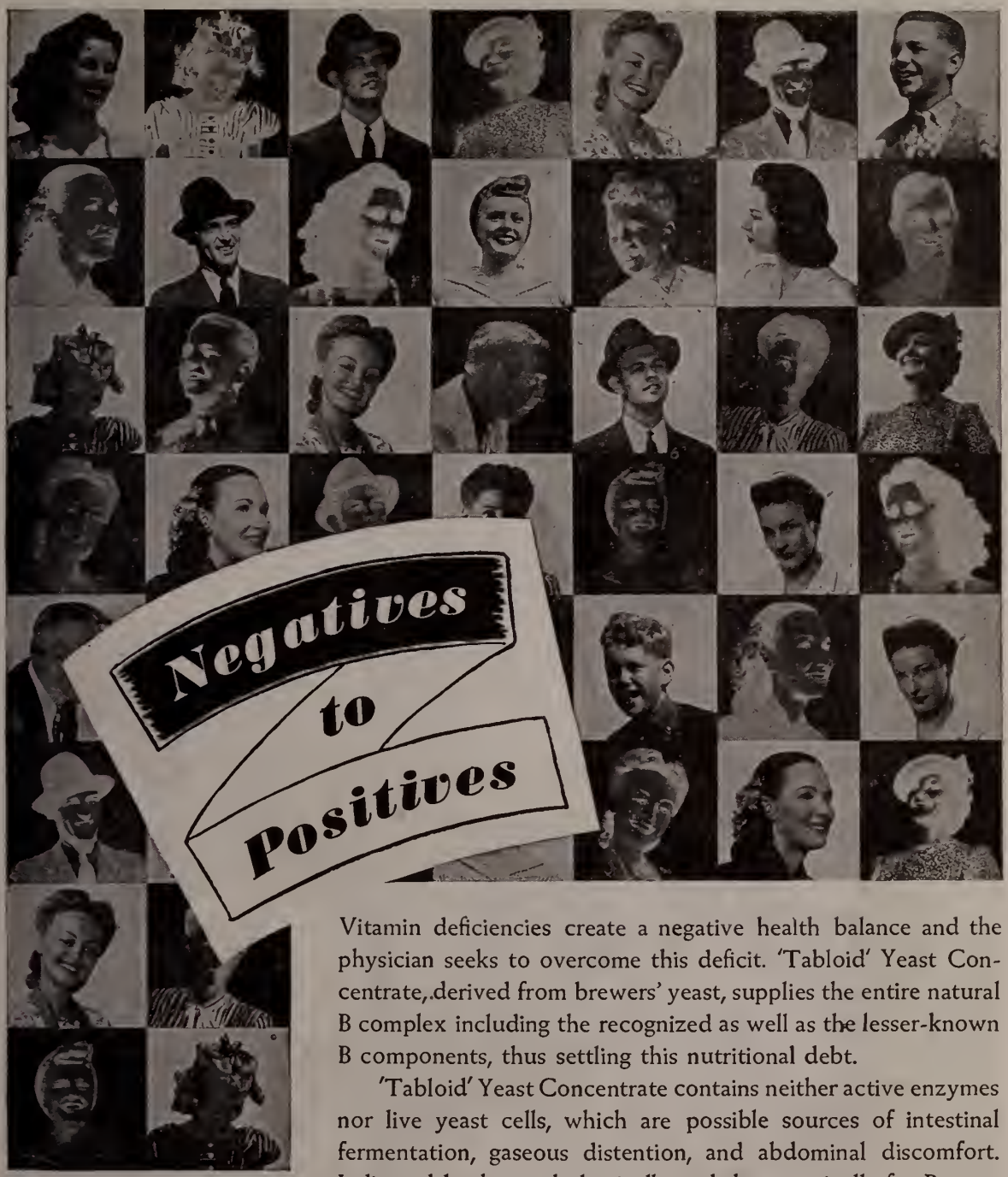
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1. Meaker, S. R., Gonorrhea, J.A.M.A., 87 :1377(1926)
2. Kleine, H, L., Cervicitis, J. Mo. State M. A., April 1939.



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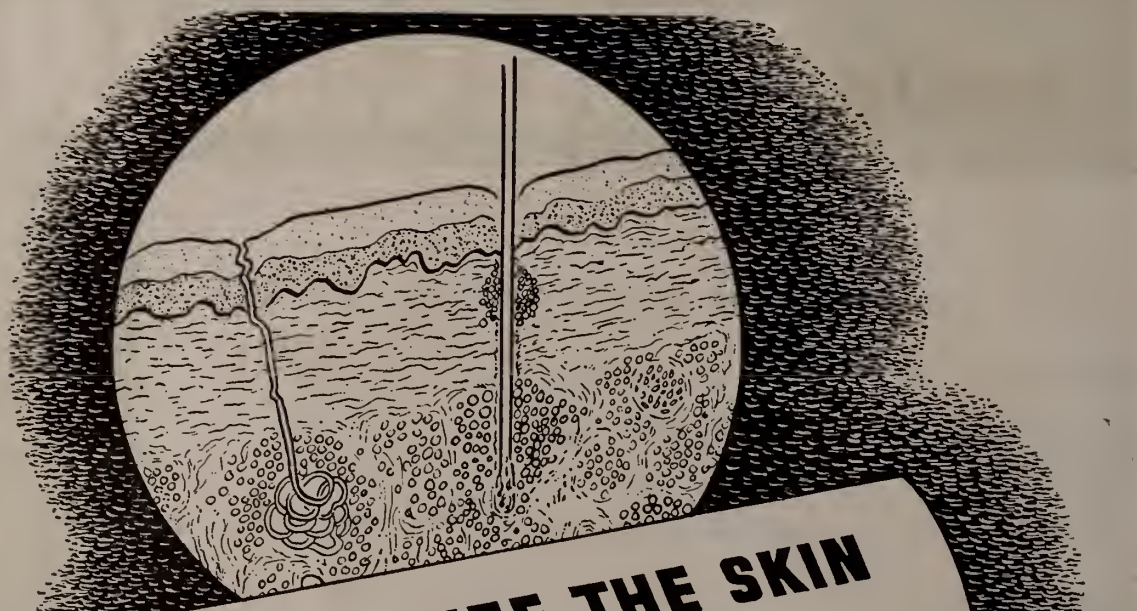
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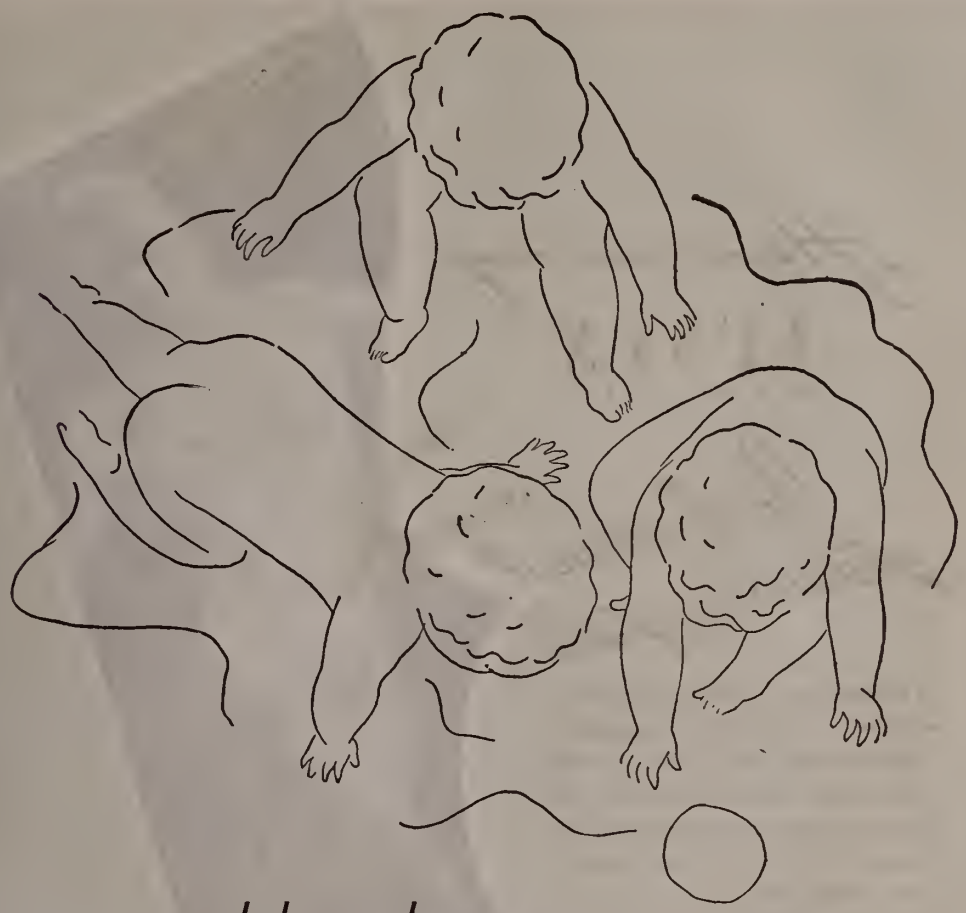


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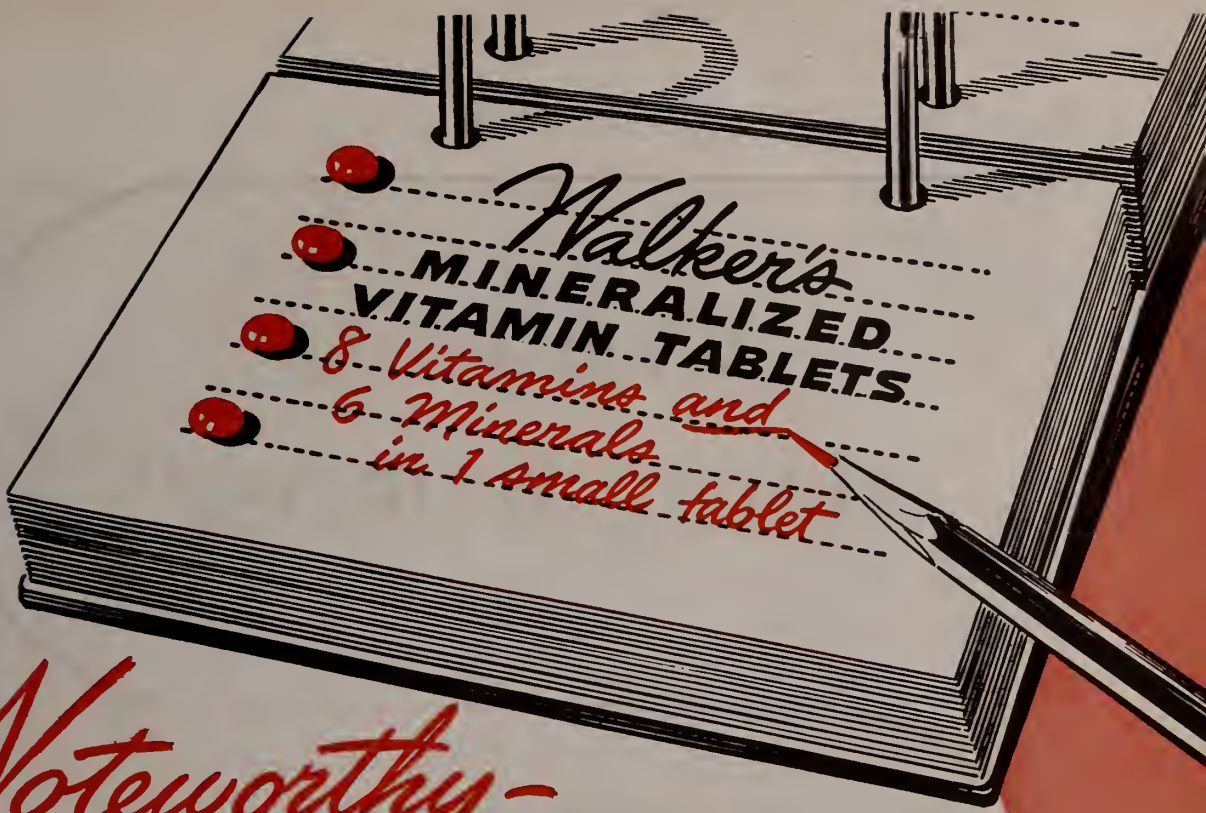
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** Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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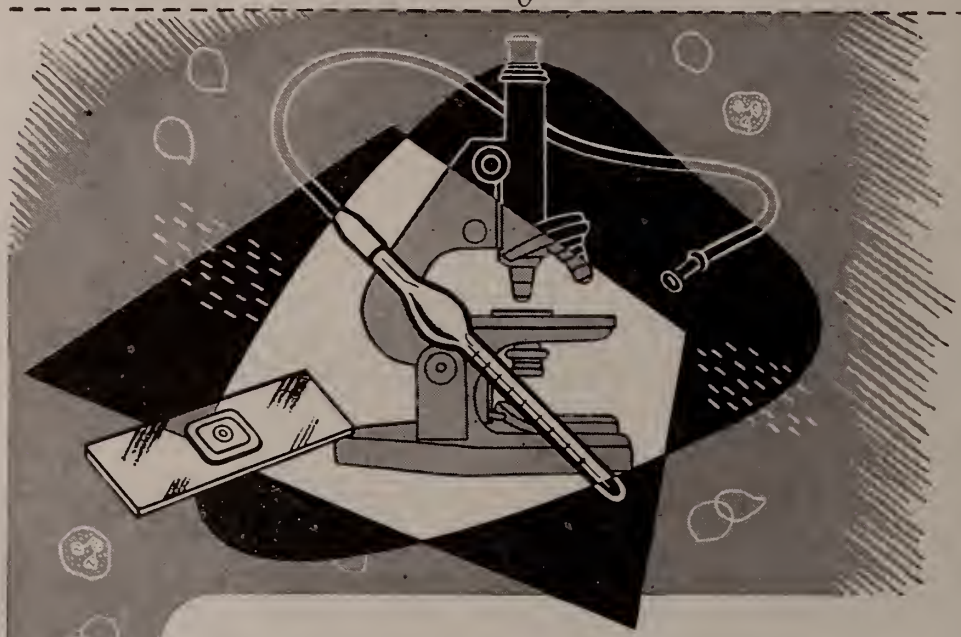


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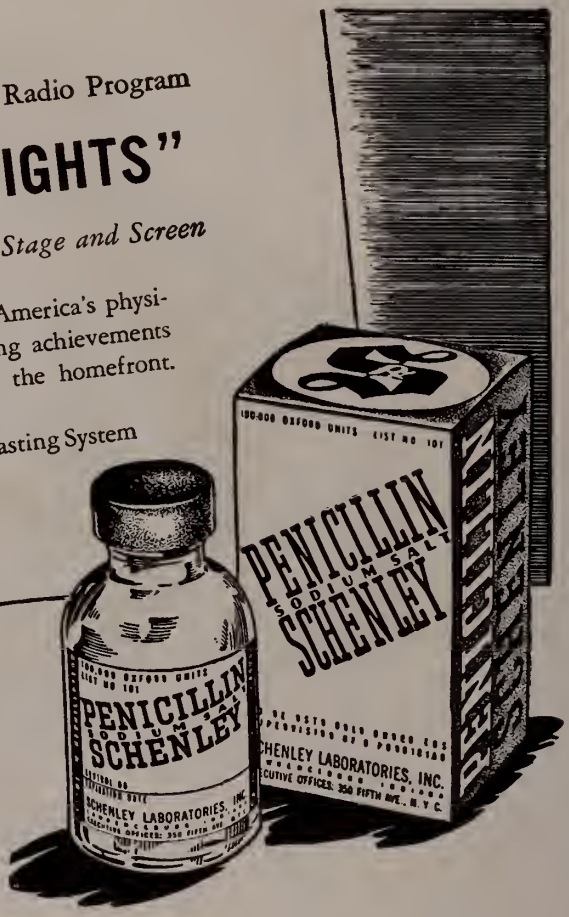
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Since 1899 SPECIALIZED SERVICE

DOCTORS DISCHARGED
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July, 1945
VOL. 88, NO. 1

The Illinois Medical Journal

Official Journal of the Illinois State Medical Society

EDITOR — Harold M. Camp. EDITORIAL BOARD — James H. Hutton, Chairman, Frederick H. Falls, Josiah J. Moore, Edwin M. Miller, Chauncey C. Maher, Harry S. Gradle, Harry Culver, Walter Stevenson, Raymond W. McNealy.

Editorials

THE JOB IS ONLY HALF DONE

Too many people have believed that, with the fall of Germany and the complete occupation of that nation by our allied troops, the war is practically over. One needs only to review the hardships encountered on Okinawa by our troops and the thousands of casualties in addition to an unusually high mortality rate from combat suffered by the United States army and navy, to thoroughly realize that the closer we get to the Japanese mainland, the more difficulty we shall encounter.

No one today doubts the final outcome, but it will not come easily as many have predicted. We shall most likely see additional war loan drives after the Seventh is complete and its quota reached. Likewise many thousands of medical officers will be needed until the enemy has been completely crushed. Several releases have appeared recently relative to release of medical officers from the services. It seems quite probable that some will be returned to civilian life, although but little information of definite nature has been received.

With approximately 4,500 Illinois physicians with the armed forces, it is quite obvious that the men remaining in civilian practice will continue to carry the unusual burdens in medical care for some time to come. They will welcome the return of those who have served their country well during the trying years since the assault on Pearl Harbor.

There are many casualties from the European fronts remaining under medical care and no doubt many thousands will continue to be in army and navy hospitals for some time to come. They must be given the best of care by the medical personnel until able to be released. Now that the European war has been brought to a successful conclusion, many stories are being told relative to the work of the medical corps and the excellent long range planning before advancements were to be made. Recent reports from the offices of the Surgeons General emphasize the previously unheard of low mortality rates in this war, which is highly complimentary to the medical officers who are not limited to any stated number of hours on duty in any day.

Reports have been received from all Illinois counties giving information desired by the A. M.A. Bureau of Information and we hope to be able to give every consideration to those returning medical officers desiring a suitable location where they can establish a practice.

Many of these men have not been in practice previously and will need more assistance than most of the older physicians. They too will receive every possible consideration and every effort will be made to give them accurate information relative to desirable locations.

In the meantime those remaining at home will endeavor to carry on to the best of their ability. We will all have great cause for rejoicing when the job is completed in the Pacific.

POST-GRADUATE CONFERENCE AT MAYO GENERAL HOSPITAL

Doctors of Western Illinois met for a post-graduate conference sponsored by the Post-Graduate Committee of the Illinois State Medical Society and arranged by the Mayo General Hospital at Galesburg.

Through the courtesy of Colonel Henry L. Krafft, Commanding Officer of Mayo General, it was possible for the visiting physicians to make a tour of the hospital escorted by Lt. Col. Bowers from 10:00 to 11:30 A. M.

The following programs were carried on during the morning:

SURGERY

ORTHOPEDIC

10:00 A.M. to 10:45 A.M. — Capt. Russell, Major Farrington, Lt. Col. Lewin. Subject: "Complicated Fractures of the Femur"

10:45 A.M. to 11:30 A.M. — Lt. Johnson, Major Farrington, Lt. Col. Lewin. Subject: "Complicated Fractures of the Humerus"

VASCULAR

10:00 A.M. to 10:45 A.M. — Capt. Carter, Major Shumacker. Subject: "Arteriovenous Aneurysm"

10:45 A.M. to 11:30 A.M. — Capt. Murray, Major Shumacker. Subject: "Peripheral Vascular Disease Requiring Sympathectomy"

NEUROSURGERY

10:00 A.M. to 10:45 A.M. — Capt. Ulin, Capt. Speigel. Subject: "Intervertebral Disc and Cranial Defects"

10:45 A.M. to 11:30 A.M. — Capt. Ehrlich, Lt. Stoll, Capt. Speigel. Subject: "Peripheral Nerve Injury"

MEDICAL

MEDICAL VASCULAR

10:00 A.M. to 11:30 A.M. — Capt. Abramson. Subject: "Peripheral Vascular Cases"

DERMATOLOGY

10:00 A.M. to 10:45 A.M. — Capt. Bloom. Subject: "Dermatological Cases"

CARDIOLOGY

10:45 A.M. to 11:30 A.M. — Capt. Christy. Subject: "Cardiac Cases"

At 12:30 the visiting doctors were entertained at a complimentary buffet luncheon at the Hotel Custer given by the members of the Knox County Medical Society.

The following program was presented during the afternoon by members of the Mayo General Hospital Staff:

ILLINOIS STATE MEDICAL SOCIETY

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PRESIDENT-ELECT ROBERT S. BERGHOFF, Chicago
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Oscar Hawkinson	3rd District, Chicago	1946
Percy E. Hopkins	3rd District, Chicago	1944
E. W. Mueller	3rd District, Chicago	1945
Chas. P. Blair	4th District, Monmouth	1946
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I. H. Neece	7th District, Decatur	1946
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ILLINOIS MEDICAL JOURNAL

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1:30 P.M. Four papers presented by:
Capt. Leo A. Kaplan
Subject: "Psychiatric Factors Delaying Recovery"
Capt. David I. Abramson
Subject: "Thrombophlebitis"
Major Harris B. Shumacker
Subject: "Traumatic Aneurysms"
Lt. Col. Philip Lewin
Subject: "Fractures of the Upper Shaft of Femur"

4:30 P.M. Each speaker headed a panel discussion. In addition, there was a panel discussion by Capt. Charles M. Schroeder and Capt. Norman T. Welford — "Use of Penicillin"

Dinner was served at 6:30 followed by a symposium on "Ruptured Intervertebral Discs" by Major Richard E. Kinzer presenting the x-ray aspects and Captain I. Joshua Speigel discussing the surgical aspects.

The meeting was well attended with about one hundred registering. The Post-Graduate Committee very much appreciated the interest and cooperation given by the officers and staff of the Mayo Hospital without which such a successful meeting would have been impossible.

CANCELLATION OF THE 1945 ANNUAL MEETING

At the regular June meeting of the Council official action was taken which cancels the annual meeting of the Illinois State Medical Society for 1945. Rulings of the Office of Defense Transportation made it unwise for the Illinois State Medical Society to even apply for the privilege of meeting this year. We will, however, try to hold a meeting of our House of Delegates this August, and when more information is available, all members of the House will receive official notice, and articles will appear in the Illinois Medical Journal.

SCIENTIFIC PROGRAMS

At this time we would like to call the attention of the members of this Society to the planning and work carried on by the General Chairman of the Committee on Arrangements, Dr. Chauncey C. Maher, and his local committees, all of whom worked under the definite handicap of uncertainty.

The officers of the various Sections have carried on and planned an excellent program to assure our membership of the customary high standards we have come to expect. We are asking all physicians who were scheduled to present papers to prepare them for publication in the Illinois Medical Journal. During the coming year you will have the privilege of seeing these presentations in your Journal. If possible a "Section Summary" will be published to illustrate the type of program which had been prepared for your pleasure and education. We will list the speakers and the subject on which they had planned to talk.

TECHNICAL EXHIBITORS

We also want to call your attention to our list of technical exhibitors who have all been notified that we will be unable to hold our 1945 meeting. Some four or five of this list had cancelled their reservations for booths in order to cooperate fully with the Office of Defense Transportation, even before we notified them of our own decision in the matter.

Many of these old friends have written and assured us that they hope to be present when we are able to hold our annual meetings again. We wish to take this opportunity to thank them for their continued cooperation, and assure them that they will be most welcome at future gatherings of the Illinois State Medical Society.

Abbott Laboratories, North Chicago
A. S. Aloe Company, St. Louis, Mo.
The American Hospital Supply Company, Chicago
The Ames Company, Elkhart, Indiana
Armour Laboratories, Chicago
Ayerst, McKenna & Harrison, New York

Bilhuber Knoll Corporation, Orange, New Jersey
Ernst Bischoff Co., Inc., Ivoryton, Conn.
The Bordon Company, New York
The Burdick Corporation, Milton, Wisc.
Burroughs Wellcome & Company, New York

Cambridge Instrument Company, New York
Camel Cigarettes, New York
Cameron Surgical Specialty Company, Chicago
The Carnation Company, Oconomowoc, Wisconsin
Chicago Pharmacal Company, Chicago
Ciba Pharmaceutical Products, Inc., Summit, N. J.
Coca Cola Company, Atlanta, Georgia

F. A. Davis Company, Philadelphia, Pa.
Doak Company, Inc., Cleveland, Ohio
Doho Chemical Corporation, New York

Eli Lilly & Company, Indianapolis, Indiana
Ethicon Suture Laboratories, New Brunswick, New Jersey

C. B. Fleet Company, Inc., Lynchburg, Va.
Flint Eaton Company, Decatur, Illinois

Gerber Products Company, Fremont, Michigan

H. J. Heinz Company, Pittsburgh, Pa.
Hoffmann LaRoche, Inc., Nutley, N. J.
Horlick's Malted Milk Corporation, Racine, Wisc.
Hospital Liquids, Inc., Chicago

Kelley-Koett Manufacturing Company, Covington, Ky.
Kellogg Company, Battle Creek, Michigan

Lea & Febiger, Philadelphia, Pa.
Lederle Laboratories, Inc., New York
Libby, McNeill & Libby, Chicago
J. B. Lippincott Co., Philadelphia, Pa.

M & R Dietetic Laboratories, Columbus, Ohio
Mead Johnson & Company, Evansville, Indiana
Medical Arts Supply Company, Chicago
Medical Business Bureau, Inc., Cleveland, Ohio
Medical Film Guild, New York
The Medical Protective Company, Fort Wayne, Indiana
The Mennen Company, Newark, N. Y.
Merck & Co., Inc., Rahway, N. J.
Wm. S. Merrell Company, Cincinnati, Ohio
C. V. Mosby Company, St. Louis, Missouri
V. Mueller & Company, Chicago
Ortho Products, Inc., Lindon, New Jersey

Parke Davis & Co., Detroit, Michigan
The E. L. Patch Company, Boston
Pet Milk Sales Corporation, St. Louis, Missouri
Philip Morris & Co., New York
Picker X-Ray Corporation, New York
Poloris Co., Inc., Jersey City, N. J.
Procter and Gamble Company, Ivorydale, Ohio

W. B. Saunders Co., Philadelphia, Pa.
Schenley Laboratories, Inc., New York
Schering Corporation, Bloomfield, N. J.
G. D. Searle & Co., Chicago
Sharp & Dohme, Inc., Philadelphia, Pa.
J. R. Siebrandt Mfg. Co., Kansas City, Missouri
Smith, Kline & French Labs., Philadelphia
Spencer, Inc., New Haven, Conn.
E. R. Squibb & Sons, New York
Frederick Stearns & Co., Detroit, Michigan
Sutliff & Case Company, Peoria

Westwood Pharmacal Corporation, Buffalo, N. Y.
White Laboratories, Inc., Newark, N. J.
Winthrop Chemical Company, Inc., New York
Wyeth, Inc., Philadelphia, Pa.

ILLINOIS PHYSICIANS GET AROUND

Illinois physicians, members of the Illinois State Medical Society, have appeared before many other state societies and presented papers on their various specialties. During the month of May numerous articles by our colleagues have appeared in medical print throughout the country. A quick glance through various exchange Journals in the editor's office reveals the following list published here for your information.

"Inversion of the Uterus. The Attending Physician's Responsibility for Immediate Replacement" — Channing W. Barrett, M.D., Chicago. May, 1945 Western Journal of Surgery. Obstetrics and Gynecology.

"The Present Status of the Prostatic Problem" — Herman L. Kretschmer, M.D., Chicago. May, 1945 Ohio State Medical Journal.

"History of Pellagra in the United States" — Paul S. Carley, M.D., Sparta. May, 1945, The Urologic & Cutaneous Review.

"Obstetrical Hemorrhages" — Frederick H. Falls, M.D., Chicago. May, 1945 Journal of the Michigan State Medical Society.

"Venous Thrombosis" — Geza de Takats, M.D., Chicago. May, 1945 Kentucky Medical Journal.

"Peripheral Vascular Disease" — Geza de Takats, M.D., Chicago. May, 1945 Journal of the Michigan State Medical Society.

Medical Economics

The Medical Economics Committee — Chauncey C. Maher, Chmn., 6 North Michigan Avenue, Chicago, Edwin S. Hamilton, V. Thomas Austin, Emmet B. Bay, Jay McDonald Milligan, Jacob M. Mora, George Halperin, Marie Wessels, Thomas C. Browning, Roland R. Cross, Milton E. Bitter, Edwin F. Hirsch, Ford Hick, Lt. Col. MC, William J. Bryan, John R. Vonachen.

MEDICAL EDUCATION

To a student of sociology the most remarkable feature of American progress is the rapid growth of our institutions. This is as true of medical education as it is of many other activities. Medical education fifty years ago was chaotic. From the exclusive Johns Hopkins, whose entrance requirements were higher than those of most European medical schools, the educational requirements ranged to the lowest level. Day schools and night schools offered diplomas. The only requirement for enrollment in most of these was the ability to pay tuition. This situation was disgraceful. From this low level medical education has been elevated to a standard that now is probably the highest in the world. This transformation was not brought about by government regulation but by the better medical schools, the universities, and the medical societies. An important part in raising the standards of medical education was played by the American Medical Association. The Association created the Council on Medical Education and Hospitals in 1904. Through its efforts the diploma mills and the poorly qualified schools were eliminated. This truly remarkable progress, in which the American Medical Association and its Council on Medical Education and Hospitals played so important a part, was achieved through methods of education and persuasion and not by coercion.

The essentials of an acceptable medical school as defined by the Council on Medical Education and Hospitals and approved by the House of Delegates of the American Medical Association, June 12-16, 1933, specify requirements of organization, administration, faculty, buildings, clinical facilities, resources, requirements for admission and curriculum.

The Council on Medical Education and Hospitals of the American Medical Association in setting up minimum requirements for entrance to approved medical schools does not specify the number of hours required but rather refers to satisfactory courses, such as English, theoretic and practical courses in physics, biology, and general and organic chemistry. While the Council's minimum requirement is two years of collegiate training including the subjects mentioned, three years or more in college have been recommended. Some medical schools have additional requirements and others require a specific number of semester hours in all required subjects.

For the guidance of prospective medical students and admitting officers, the Council publishes annually a compilation of colleges of arts and sciences approved by the following agencies: Association of American Universities, Middle States Association of Colleges and Secondary Schools, New England Association of Colleges and Secondary Schools, North Central Association of Colleges and Secondary Schools, Northwest Association of Secondary and Higher Schools, Southern Association of Colleges and Secondary Schools. This list may be obtained for five cents from the Order Department of the American Medical Association. Medical Schools sometimes accept applicants who have fulfilled the requirement in American and Canadian institutions not approved by the agencies mentioned, provided the applicant gives evidence of superior ability. Prospective medical students should secure their premedical training in col-

leges of this list. Since success in the medical curriculum demands more than average intelligence and industry, the college student who is not in the upper third of his class should seriously question the advisability of starting a medical career.

In 1931, the Association of American Medical Colleges passed a resolution recommending aptitude tests as an additional guide in the selection of students. Many of the schools base their decisions in part, on the aptitude scores.

Medical Education

Sixty-six approved medical schools in the United States offer the complete medical course. Ten schools for the basic medical sciences are developing four year programs, started in 1943, but now are approved only as schools for the basic medical sciences.

Schools which offer only the first two years of the medical curriculum are designated as schools of the basic medical sciences. The majority of these schools are in small communities where the material required for clinical teaching is limited. In some schools, facilities for teaching satisfactorily such subjects as physical diagnosis and gross pathology must be sought elsewhere. Introductory courses in medicine and surgery which commonly form a part of the second year schedule also have this disadvantage. Officers of these schools assist their students to secure enrolment in four or five medical schools in order to complete the medical curriculum.

Six medical schools in the United States require a year of internship or research as a part of the medical course, thereby lengthening the course to five years.

The standard curriculum recognized by the Council on Medical Education and Hospitals and contained in its Essentials of an Acceptable Medical School is as follows:

Curriculum. The entire course of four years shall consist of from 3,600 to 4,400 hours, distributed in from 900 to 1,100 hours per year, and shall be grouped as set forth in the following schedule, each group to be allotted approximately the percentage of hours of the whole number of hours in the courses as stated. Table 1.

When the teaching conditions conflict, a subject may be transferred from one division to another.

TABLE 1

	Hours	Per Cent
1. Anatomy, including embryology and histology	14	18.5
2. Physiology	4.5	6
3. Biochemistry	3.5	4.5
4. Pathology, Bacteriology and Immunology	10	13
5. Pharmacology	4	5
6. Hygiene and Sanitation	3	4
7. General Medicine	20	26.5
Neurology and psychiatry		
Pediatrics		
Dermatology		
8. General surgery	13	17.5
Orthopedic surgery		
Urology		
Ophthalmology		
Otolaryngology		
Roentgenology		
9. Obstetrics and gynecology	4	5
Total	76	100
Electives	24	0

The Accelerated Program

Medical schools of the United States have recognized that the national war emergency has created the need for a larger number of well qualified physicians. All medical schools have initiated an accelerated program to increase the supply of physicians for the Army, the Navy and the civilian population. The plan provides for the utilization of the long summer vacation as a teaching period and, by continuing the schedule throughout the calendar year, the four academic years of the medical course are completed in three calendar years.

Sixty-three four year schools have adopted the accelerated curriculum involving both the acceptance of entering students and the graduation of a class every nine months. One school will graduate a class every nine months during the next three years but will admit entering classes on an annual basis. The university of Tennessee College of Medicine will continue to operate on the four quarter plan which provides for the admission of students at any quarter and the graduation of students quarterly. The Woman's Medical College of Pennsylvania, which is on the accelerated program for the junior and senior years only admits new first year students once a year. All ten schools of the basic medical sciences have adopted an accelerated program.

Student Enrollment

As a war measure, the medical schools of this country have increased the size of their entering

classes by approximately 10 per cent. They have adopted an accelerated program which provides graduation of a class every nine months and sixty-three four year medical schools will accept entering students every nine months. According to estimate, more than 20,000 students will be graduated from the medical schools of this country between July 1, 1942 and July 1, 1945, or about 30 per cent more than would have been graduated without the adoption of the accelerated programs and increased enrollments.

Military Service

The Army and Navy have contracted with practically all medical schools to provide instruction to students in the Army Specialized Training and Navy V-12 Programs. Approximately 80 per cent of the places in medical schools have been occupied by soldiers and sailors assigned to this work. These include physically qualified men now in medical schools or admitted to classes commencing the medical work in 1944. These men are selected from A.S.T.P. and Navy V-12 premedical groups by the Army or Navy in close collaboration with representatives of medical colleges and the premedical schools. Such students are in uniform and receive base pay, tuition and other expenses. In all except a few schools, Army students receive allowances and live where they wish. No Navy students are housed in barracks.

Approximately 20 per cent of the places in medical schools under Army and Navy contract remain for civilian applicants, who apply for admission as in peace times.

The curriculum is unchanged, except that acceleration is compulsory for all Army and Navy students.

Upon completion of the medical course, Army and Navy students are returned to inactive status with reserve commissions for the internship. Students select their own internships and hospitals their own interns, as before.

Internship

Practically all medical students plan to serve an internship in a hospital following completion of the medical course. An internship is required for the M.D. degree by six medical schools in the United States. The state licensing boards in twenty-two states, the District of Columbia, Alaska, Hawaii and Puerto Rico require that all applicants for licensure shall have served a hospital internship. While some of the bodies named above have their own lists of hospitals recommended for intern training, generally the Council's list of Hospitals Approved for Internships is followed. A copy of this list is available on request.

For the duration of the war, the internship period will be nine months, with provisions for additional hospital work as assistant residents and residents for selected men holding reserve commissions. Two-thirds of the commissioned men may expect to enter active duty as medical officers after completion of a nine-month internship.

There are four medical schools in Chicago. The requirements for admission, the curriculum and the general course are patterned very much in accordance with the plans described.

G.H.

PENICILLIN IS USED SUCCESSFULLY IN INFECTIOUS DISEASE FROM PARROTS

The first successful use of penicillin in the treatment of human psittacosis, an infectious disease of parrots which is transmissible to human beings, is reported by three Philadelphia physicians—Harrison F. Flippin, Michael J. Gaydosh and William V. Fittipoldi—in the May 26 issue of *The Journal of the American Medical Association.*

The doctors report the case of a 52-year-old woman who contracted the disease after being bitten on the finger by a parrot. She suffered a migratory type of pneumonia which failed to respond to the sulfonamides. Penicillin treatment was instituted on the 19th day of illness, and there was a definite improvement within 36 hours.

The disease, caused by a virus, was practically unknown in this country until a number of cases were reported in 1929-30. The majority of patients at that time gave a history of close contact with parrots or with sick love birds. It is believed that the infection incurs by inhalation. The mortality rate in different outbreaks has averaged about 20 per cent.

State Department of Public Health

STATISTICS AND HEALTH PROGRESS

The average length of life of the American people in 1942 corresponding to the mortality conditions then current was 64.8 years while in 1900 life expectancy at birth was only 49¼ years. Thus it is possible to summarize in a single sentence the entire effect of over 40 years of progress in methods for the protection of life. The function of *vital statistics* is in part to produce such succinct evaluations of the multiplicity of events as those represented by all the births and all the deaths which took place in a 43 year period. It also devolves upon the science of vital statistics to show how and why the life span has been extended and what may be reasonably expected in the near future.

Through the analysis of all the births, deaths, and morbidity from notifiable diseases the vital statistician is able to focus attention on what are the problems in the protection of life and the prevention of disease and other physical disablements. As such, vital statistics are recognized as the essential tool in forging public health policies and in allocating public health resources. It is for this reason that in the United States the registration of births and deaths has been made the responsibility of public health authorities. In many states the registration of marriages (and divorces) is also carried out by health departments in order that the statistics of this important event in the human life cycle may be available for analysis in conjunction with the other vital data. (Unfortunately in Illinois meaningful marriage statistics cannot be had because the records are kept by the county clerk of each county along with a multitude of other kinds of records in his charge.)

While births, deaths, morbidity, and marriage together with the enumeration of the population form the basic vital data from which vital statistics are drawn, there is also a large body of statistical information which originates as by products of official public health activities. Among these are the distribution of medical, hospital, and other health facilities; the levels of immunity to certain diseases and the levels of sanitation in various areas; the industrial hazards to life and health in certain communities; the extent and distribution of public health activities. Health departments find it necessary to correlate all these diverse kinds of information in order to conduct their work in the most effective way.

The development of co-ordinated health statistics to include all these related types of health information is in its infancy. The need has long been recognized, but facilities have been lacking. First, it is necessary to have vigorous *local* public health departments. The existence of such organizations is in turn dependent upon an alert medical profession and an enlightened public opinion. Second, it is necessary to have a high-grade, modern state health department capable of co-ordinating the work of the local organizations, sustaining them in their development, setting standards of health protection, making known the progress in medical science and public health methods, and defining the over-all health problems. Third, it is necessary that well trained statistical personnel as well as physicians, dentists, nurses, and sanitarians be available to both the local and the state organizations. The full development of statistical services necessarily lags behind that of the direct health

services because refined knowledge of conditions and problems is hardly necessary when every recognizable problem is a major one and rule-of-thumb methods bring gratifying results. Also, good statistical services just as good medical services cost money. Since the costs of statistical service are an "overhead" expense, it is little wonder that statistical practice in public health lags far behind the theoretical development of the act.

Wherein do public health statistics concern the medical profession at large? Why should the private practitioner give them even second thought? Does not the specialist have enough trouble keeping abreast of his specialty while the general practitioner almost futilely struggles to keep sufficiently informed on a modicum of the specialties? The answer must of course be: "Yes, but —." In the first place, every private practitioner has a direct stake in public health since the sphere of public health activity is in those areas of medical service which cannot be handled by the individual practitioner nor by voluntary groups of practitioners alone. It is therefore necessary for the practitioner to understand as much as he can about what the public health problems are and what the public health authorities are doing about them. Statistics properly presented give the answers in a nutshell. Secondly, the vital statistics of births, deaths, and morbidity correctly interpreted give him the knowledge whereby he can orient himself in the general conditions surrounding him in his practice and in the community. Finally, he is the primary source of vital data since it is the private practitioner who reports the births he attends, the deaths of his patients, and the cases of infectious disease which present themselves.

Although duty is not as fashionable a concept nowadays as in 1908, the engaging arguments of Dr. H. B. Hemenway of Evanston[1] as to the duty of the physician to faithfully report births, deaths, and morbidity from contagious disease still hold. Dr. Hemenway makes the point (1) that every physician is a quasi public official, (2) that under the law he is required to make such reports, and (3) that he should comply with the spirit of the law. While completeness of reporting on the part of physicians is now far better than in 1908, there is still a noticeable lack of compliance with the spirit of the law. Under the law the medical certificate of death should "furnish such information as may be required by the Department of Public Health in order to properly classify the death." Nevertheless, careless statements as to the cause of death are all too frequent and a reliable determination of the basic or underlying cause of death is impossible. Too much information is as bad as too little when the medical certificate merely inventories all the pathological conditions found on autopsy without an opinion rendered either by the pathologist or the clinician. Nor has the recent progress in standardization of the nomenclature of diseases and operations been observable in the statements of death causes on the medical certificate. For a proper understanding of registering both births and deaths each physician should have available for reference a copy of the handbook[2] published by the U. S. Bureau of the Census and available free of charge from the State Department of Public Health. This little book states briefly the purposes of registration and gives a simple discussion on the medical certification of cause of death together with a complete tabulation of the International List of Causes of Death.

Until physicians generally recognize their responsibility for accurate and conscientious reporting, no amount of skill on the part of the statistician can compensate for the deficiencies in the basic data which result from inadequate reporting. Progress in good vital statistics depends on the progress of the medical profession in effective diagnosis and its use in preparing the medical certification of death. Progress of this sort has been definite and it is gratifying to see the excellence of the certifications coming from the outstanding medical centers and from the younger members of the profession. As the original information improves, it will then become possible to answer whether the incidence of cancer is increasing commensurately with the increased death rates therefrom, or whether the increase means only better recognition of the disease.

[1] H. B. Hemenway "Public Duties of Physicians" Illinois Medical Journal, January 1909. Read before the Chicago Medical Society, Nov. 11, 1908.

[2] U. S. Bureau of the Census: "Physician's Handbook on Birth and Death Registration" U. S. Government Printing Office, 1939.

Where should we look for health progress now? Life expectancy statistics show that while white females at birth can expect 68.6 years of life, the colored female has an expectancy of only 58 years. Similarly, white males have an expectancy of 63.6 years as opposed to only 54.3 for the colored. This we recognize as not merely a medical problem, but also a socio-economic one. In any event, much can be done and undoubtedly will be done. And what about our babies? The child at the age of one can expect 66.6 *additional* years of life while at birth his chances are for only 64.8 years. Thus despite the great progress in curbing infant mortality, we still find a big problem both for medical research and for medical practice. The human cost of reproduction has dropped amazingly to a little more than one-third of the cost in 1929. But over one-third of the current maternal mortality of less than 2 per 1,000 live births is attributable to puerperal septicemia. Tremendous progress has been made in eliminating infectious and contagious diseases as numerically important causes of death but we nevertheless still find mortality from diseases largely preventable. While we must accept with resignation the greater increase of death from degenerative disease as the price of our lengthening life span, we are still confronted by the too frequent deaths from rheumatic fever in the younger age groups and its disabling and fatal effects in those who survive the initial course of the disease. Your vital statistics will measure the extent of progress with these health problems and will continue to point out the new areas for work as the older problems approach their solution.

PUBLIC HEALTH NURSING IN THE STATE DEPARTMENT OF PUBLIC HEALTH

Public Health Nursing was a part of the Division of Child Hygiene from 1919 to 1941. In August of 1941, Dr. Roland Cross, the Director, established a separate Division of Public Health Nursing, and it therefore took its place as one of the several Divisions of the Illinois Department of Public Health.

All public health nurses employed by the Department come under the technical supervision of the Division. The staff includes, in addition to the Chief Supervising Nurse, an Educational Director, and nine advisory and consultant nurses. The consultant nurses serve such special fields as tuberculosis, venereal disease, industrial hygiene and maternity and infancy hygiene. Through these nurses, assistance is given the field staff of public health nurses who number 120. These field nurses serve in county or district health departments and are administratively responsible to a county or district health officer.

The Division of Public Health Nursing also carries on a continuous program of staff education designed to meet the needs of all public health nurses in the state. It sets standards in public health nursing and assists in maintaining them. The recruiting of possible applicants for public health training is also another activity of this Division.

Nurses comprise the largest single professional group engaged in public health work. At the present time, there are 1250 employed in Illinois, working in various public health nursing fields, including those services financed by the official agencies; namely, the state, city and county health departments, county tuberculosis sanitorium boards, boards of supervisors and boards of education, and those serving under private or unofficial agencies such as visiting nursing associations, tuberculosis associations and insurance companies. There are nurses employed by industrial plants.

The first public health nursing was limited to the care of the sick in the home, but with the newer developments in the field of preventive medicine, the service has been extended to include teaching in simple terms the important scientific principles of sanitation, prevention of disease and healthful living. Today, public health nursing services embrace activities for all age groups from prenatal and maternity through infancy, preschool and school age and adult life.

The public health nurse is now well established in this country and most communities accept her and her services as essential to the well being of their citizens. The generally accepted standard which we should like to achieve is one public health nurse for each 2,000 persons in the general population. Few communities have reached this goal, but when the war is over, the possibilities of expanding health department services are most encouraging.

The trend in all public health nursing services is toward a generalized nursing program. The specialized plan has been the more common form of service in Illinois in the past and has proven valuable in demonstrating results, but the generalized plan has been widely recognized as the more complete form of service to families of the community, while at the same time preventing duplication of service and an extravagant use of nurse power.

With the entire family as the unit, the same nurse may give service in communicable disease, venereal disease, tuberculosis, antepartum, delivery, postpartum, infant, preschool, school, and adult hygiene, morbidity service and crippled children service.

Nurses who are employed by the State Department of Public Health must meet the qualifications set up by the Civil Service Commission for the various classifications of positions.

The public health nurse must be a registered nurse and she must have special training in public health nursing at a university before she is qualified to enter the public health nursing field. In the State of Illinois, public health nurses who are paid from public tax funds are required to take an examination for certification as a public health nurse. This is a legal requirement and is under the supervision of the Department of Registration and Education. Certification requires a minimum of one semester's academic work in an approved school of public health nursing and one year of field experience in public health nursing under the supervision of a registered and certified public health nurse.

The Department of Public Health has given scholarships to desirable applicants for public health training ever since Social Security funds were available in 1936. Since that time, two hundred registered nurses have been given training, spending from four months to a year in a school of public health.

Since medical service is involved in every type of public health nursing activity, the appointment of a Medical Advisory Committee is one of the necessary first steps to be taken in the establishment of any program of public health nursing. The County Medical Society usually selects this committee from among its members.

Meetings are planned at frequent intervals with the Medical Advisory Committee in order that the physicians may have an opportunity to give constructive leadership and help in respect to program planning and the proper shaping of medical policies and procedures. All nursing techniques are approved by the committee and careful plans made with them for such programs as medical examinations, immunization campaigns, etc.

In all services which the public health nurse renders, she relies upon the physician for medical care and guidance. She stands ready at all times to aid him in giving skilled nursing care to the patient in his home and to assist him in program planning to meet the health problems of his community and prevent unnecessary disease and death.

DIPHTHERIA VANISHING IN ILLINOIS

In 1920 there were 14,375 cases of diphtheria reported in Illinois. In 1944 there were only 314 cases reported. During the five years ended with 1924 a total of 67,930 cases was reported. During the five years ended with 1944 the total reported was 3,592. This remarkable contrast is the result of the cooperative efforts of the medical profession and the public health agencies of the State in the immunization of children against diphtheria.

The record compares favorably with the experience in certain foreign countries during the war from which reliable information is available. More than 900 children died from diphtheria in England and Wales during the European part of the war, for example. This is a larger number than that of children killed by bombing in England and Wales. Likewise in Norway diphtheria caused widespread illness and heavy mortality after the German occupation. Immunization had been neglected in both England and Norway.

In Illinois the program against diphtheria has been cooperative from the outset. Most of the medical work of giving toxoid has been done by private practitioners, much of it in their offices. The State Department of Public Health has provided toxoid free of local cost. It has carried on educational campaigns unceasingly to encourage parents to have their children immunized. Local health departments have been active in this way also. The State has provided free laboratory service for the diagnosis of diph-

theria. Through this general effort the record referred to above has been achieved.

In the last five years the number of case reports per year has varied from 940 to 314, the latter being the lowest on record. Most of the incidence has resulted from local epidemic outbreaks, sporadic in character. The reason for this is the lack of local public health machinery. The personnel strength of the State Department of Public Health is not sufficient to carry on the persistent and continuing local programs throughout the State that are needed in order to prevent sporadic epidemics of diphtheria.

This leads inevitably to the conclusion that better local health departments are needed to reduce diphtheria to the vanishing point, as it has been in some states, and to prevent its recurrence. Every generation of children must be immunized as they come along in order to keep diphtheria from appearing again after it has been eradicated from a community. This requires continuous effort on the part of public health workers.

Much the same thing may be said about numerous other diseases such as smallpox, typhoid fever and whooping cough. While the methods of control vary, efforts may never cease without risking the reappearance of any controllable disease.

The development of county health departments is based on this kind of thinking. During the last two years eight counties have taken advantage of the law passed in 1943 which permits the establishment and maintenance of autonomous county health departments. The eight counties are: Adams, DuPage, Edwards, Lawrence, McLean, Montgomery, Morgan and Wabash. In four of these, Adams, DuPage, McLean and Montgomery, the people voted to levy a special tax for the support of the health department. In the other four, the health departments are financed from the general county funds.

FIND RED BLOOD CELLS CAN BE KEPT LONGER IN CORN SYRUP SOLUTION

A wider use in the transfusion of type O blood cells, which are left after plasma is removed from whole blood, is now possible through the discovery that a 10 per cent solution of corn syrup in distilled water serves as a better medium for preservation of these cells than any other solutions so far tried, according to a report of two Red Cross doctors in the April 28 issue of *The Journal of the American Medical Association.* The physicians are William Thalhimer, M.D., Associate Technical Director, Blood Donor Service, American Red Cross, New York, and Major Earl S. Taylor, Medical Corps, Army of the United States, Technical Director, Blood Donor Service, American Red Cross.

These red blood cells, which can be used in transfusions of the wounded in battle without the necessity of determining the patient's blood type, are obtainable in huge amounts by centrifuge in the preparation of blood plasma from the many hospital blood banks and the extensive American Red Cross blood procurement program for the armed forces. While it is recognized that the transfusion of red blood cells serves as well as whole blood for many patients, the main problem has been, they say, "to find a solution for resuspension which will preserve the cells for a long enough time to make their use practical. . . ."

This report is based on 761 transfusions of centrifuged type O cells resuspended and stored in 10 per cent corn syrup up to sixty days and administered to 437 patients, many of whom received repeated transfusions, some daily and some several times a week.

It was found that 10 per cent corn syrup in distilled water successfully preserved the cells for as long as sixty days. Solutions of sodium chloride containing the proper percentage of salts to keep the red blood cells unaltered has been used extensively but is far from ideal, the authors say, "in that it is necessary to administer the saline-suspended cells not later than five days after the blood is obtained from the donor. . . .

"The clinical improvement has been what could be expected from the administration of the same amounts of whole blood of the same age, and the same increase in the patients' total red blood cell count and nonagglutinable (transfused type O cells) red blood cells occurred. Careful observation revealed no unusual or deleterious effects, a low fever-chill reaction rate and the absence of hemoglobinemia, hemoglobinuria or jaundice in any of the patients. . . ."

Correspondence

CARE OF SOLDIERS ON FURLOUGH

Army Service Forces
Headquarters, Sixth Service Command
Chicago 6, Illinois

14 June 1945

Dear Doctor:

Due to the large number of returning soldiers who will be placed on leave and furlough during the next months, civilian physicians will be called upon to care for many illnesses and injuries. In order that the policy which provides remuneration for such services may be disseminated, it is requested that the following regulations governing treatment given under above circumstances be published in the State Medical Journal.

"In order to receive civilian medical treatment at Government expense, military personnel must be on *authorized* leave, pass or furlough in an area in which Government facilities for such treatment are not available within a reasonable distance.

"The physician or hospital rendering treatment must notify *without delay*, by wire or letter, the Commanding General, Sixth Service Command, 20 North Wacker Drive, Chicago 6, Illinois, attention the Surgeon. The notification must give the name, rank, organization and station of the person treated, the diagnosis and the estimated duration of treatment.

"Treatment will be limited to conditions of an acute nature, and no surgical procedures except in emergency will be accomplished without the approval of this headquarters. Treatment of elective medical or surgical conditions is not authorized, and laboratory procedures considered nonessential to the diagnosis and treatment are not compensable.

"Private rooms and special nurses will not be provided without authorization from this headquarters.

"On completion of treatment, an *itemized* statement will be mailed to this headquarters covering all services rendered."

Very truly yours,
Don G. Hilldrup
Colonel, M. C. Surgeon

CHICAGO UROLOGICAL SOCIETY HAS ELECTION

At the annual meeting of the Chicago Urological Society held May 24, 1945, the following officers were elected: — President — Dr. Frederick W. Schacht; Vice-President — Dr. Harry J. Dooley; Secretary-Treasurer — Dr. James W. Merricks.

MEDICO-LEGAL CONFERENCE AND SEMINAR OCTOBER 1-6, 1945

The Department of Legal Medicine of the medical schools of Harvard, Tufts, and Boston University in association with the Massachusetts Medico-Legal Society will present a six-day program of lectures, conferences, and demonstrations having to do with the investigation of deaths in the interests of public safety. Attendance during five of the six days of the course will be limited to fifteen persons who have registered in advance. On one day (October 3) the program will be open to any physician, lawyer, police official, or senior medical student who may care to attend.

Further information may be obtained from the secretary of the Massachusetts Medico-Legal Society, 25 Shattuck Street, Boston.

TRAINING OF PHYSICAL THERAPISTS

Dear Doctor:

I want to call your attention to the National Foundation's special program for the training of physical therapists and the development of physical therapy.

An appropriation of $1,267,600 by the National Foundation makes it possible to offer scholarships to young men and women who have been graduated from accredited schools of nursing or physical education, or who have completed a minimum of two years of college work with emphasis on biology and other basic sciences. Candidates with the proper prerequisites will be trained at physical therapy schools approved by the Council on Medical Education and Hospitals of the American Medical Association.

This program was developed with the advice of a special committee composed of Dr. Irvin A. Abell, of Louisville, Ky., chairman, and Dr. Donald B. Armstrong, of New York; Dr. Max M. Peet, of Ann Arbor, Mich.; Dr. Morris Fishbein, of Chicago; Dr. Arthur L. Watkins, of Boston; Dr. M. G. Westmoreland, of Chicago; Miss Jessie Stevenson, of New York, president of the American Physiotherapy Association; Miss Lucille Daniels, acting director of the division of physical therapy, Stamford University, Calif.; Dr. Don W. Gudakunst, medical director of the National Foundation; Miss Catherine Worthingham, director of technical education for the Foundation, and myself.

The committee feels that the lack of qualified physical therapists today has hindered physicians from making a wider use of physical therapy in various medical specialties.

Students receiving these scholarships will be trained for treatment of all types of illness and disability in which physical therapy is used, so that they will be equipped to serve under the supervision of doctors in various kinds of practice. We are not asking scholarship recipients to restrict their activities to the treatment of infantile paralysis patients. Instead, a pool of skilled professional workers will be made available; they may be called in time of infantile paralysis outbreaks but they are not trained in the care of infantile paralysis alone.

We also will continue to aid approved physical therapy schools to expand their facilities so that larger numbers of students may be trained. At the same time, we hope to increase the numbers of qualified teachers available to staff these schools, by offering a number of teaching fellowships to experienced physical therapists who seem to be promising potential instructors.

The new program will help fill the urgent need for competent workers in physical therapy. Although the first scholarship students have started their studies, it will not be until the summer of 1946, at the earliest, that any increase in numbers of new physical therapists will take place. At that time we trust you and your colleagues will begin to find at least one of the major obstacles to the wider use of physical therapy partially removed.

Sincerely yours,

Basil O'Connor, President,
National Foundation for
Infantile Paralysis

NEW CLEARVIEW DIAGNOSTIC TREATMENT BUILDING

On June 10, Clearview, owned and operated by Dr. and Mrs. Albert L. Crane, formally dedicated their new diagnostic treatment building on the Kratzville Road, Evansville, Indiana. With this increase in bed capacity at their institution, Clearview is better enabled to properly give electro-shock therapy, insulin shock therapy, Malaria, alcoholic conditioned reflex treatment, etc.

Clearview has been operating since September, 1941, and the increase in patient load necessitated the enlargement of their quarters. At the dedication on June 10, C. C. Herzer, M.D., president, Vandenburgh County Medical Society, and Congressman Charles M. LaFollette appeared on the program.

CHICAGO DERMATOLOGICAL SOCIETY ANNOUNCES NEW OFFICERS

The present officers of the Chicago Dermatological Society are as follows: — President — Frederick R. Schmidt, Chicago, Illinois; Vice-President — M. J. Reuter, Milwaukee, Wisconsin; Secretary-Treasurer — Marcus R. Caro, Chicago, Illinois.

★ BUY ANOTHER BOND ★

Medicine's Role in the War Effort

GENERAL KIRK REPORTS ON MALARIA EFFECTS

Fear due to lack of information can cause more harm than malaria itself. Major General Norman T. Kirk, Surgeon General of the Army, declared in his first public report on the effects of this disease on the individual.

With the prospect of thousands of soldiers returning to this country from malarious regions, General Kirk made an appeal for a better understanding of the problem so the public will realize that, with a few simple precautions, malaria is not a disease that should give undue concern either to infected service men or to their families.

"The soldier who, through ignorance, worries about malaria and the chances of relapses," he said, "will suffer more ill consequences than the man who understands that with proper care this disease is not of serious import from the standpoint of the patient's general health. This very knowledge will contribute considerably to the individual's well-being and fitness."

General Kirk pointed out that families should not consider soldiers infected with malaria a menace to them or the community, provided the malaria sufferer is taking treatment or promptly obtains medical care when symptoms occur.

There are a number of types of malaria, but the two that concern American troops are benign tertian malaria, which is rarely a serious disease, and malignant tertian malaria, which without treatment may be fatal. The latter type is cured by atabrine so that it is not a problem when properly treated. The attacks of malaria which soldiers will suffer after return to this country will be due to benign tertian malaria. This is the one type which is of military significance to American troops.

The service man infected with benign tertian malaria can continue with his usual arduous combat duties as long as he takes the necessary small doses of atabrine. Benign malaria is rarely cured by atabrine. However, this drug suppresses the disease. When a man with benign malaria stops taking atabrine, the usual symtoms -- chills, fever, headache, and nausea — may appear.

In the majority of cases the disease has run its course after a man has suffered a few relpases, and no permanent damage has been done. Out of 1,000 cases, about one third will have only one attack. There will be about 40 out of 1,000 who will suffer ten relapses, and only about one in 1,000 will have as many as 20 attacks. Relapses become less acute as time goes on.

When attacks do occur, the symptoms are rapidly relieved and all progress of the disease is quickly suppresed if the proper medical care is given the patient. In most cases this can be accomplished within 48 hours, according to General Kirk.

"As a result of prompt and efficient action," he said, "attacks of malaria by themselves cause only brief incapacitation and result in no permanent damage tc the body."

General Kirk stressed the point that malaria can be spread only by the anopheles mosquito. Even if a man is infected, the anopheles mosquito cannot transmit the disease unless it has bitten the victim during a relapse and before medical treatment has been secured. In most parts of the United States there is little likelihood of this since mosquito control measures are adequate.

Infected individuals who are not taking regular suppressive medication are particularly subject to relapses if they engage in strenuous work, or if they suffer from exposure, or if they indulge in drinking to excess.

One phase of malaria treatment that causes concern to many victims is the yellow color the skin takes on as a result of using atabrine. This color is not due to jaundice or any other malfunctioning of the body. It is caused directly by the yellow color of atabrine which is deposited in the skin. The yellowness will disappear a few weeks after the use of the drug is discontinued.

Deaths due to malaria since the beginning of the war have been rare. They are nearly always associated with other diseases and with circumstances which cause delayed or inadequate treatment, Army records

show. In the early stages of the Pacific war, malaria did more damage to American soldiers than Jap bullets — in disabling troops, but not in killing them.

★ ★

SURGEON GENERAL OUTLINES PERSONNEL RELEASE POLICY

Substantial releases of Army Medical Department personnel will not take place before the latter part of this year, Surg. Gen. Norman T. Kirk said in announcing a policy on discharges in conformity with War Department procedures. This is due to the fact that the peak of the Medical Department's activities will not be reached until fall.

In formulating the policy, consideration was given to civilian needs for professional medical, dental and veterinary care without weakening military needs. Other factors considered were the length of time necessary for personnel to complete their work in the Mediterranean and European theaters and return to the United States; replacement of Medical Department personnel in active theaters by those who have not had overseas duty; necessity for the maintenance of a high standard of medical care; the heavy load of patients in the United States; evacuation of the sick and wounded from Europe in the next ninety days, and continuing medical service in the Pacific.

The policy applies with equal effect to Army medical officers assigned to the Veterans Administration and other agencies.

It reads:

Medical Corps

(*a*) Officers whose services are essential to military necessity will not be separated from the service.

(*b*) Officers above 50 years of age whose specialist qualifications are not needed within the Army will receive a high preferential priority for release from active duty.

(*c*) Adjusted service ratings will be utilized as a definite guide to determining those who are to be separated.

Medical Administrative Corps

(*a*) Officers whose services are essential to military necessity will not be separated.

(*b*) Officers who express a desire to stay on duty shall be allowed to do so if vacancies exist. In the event there are more wishing to stay than there are vacancies, those with the highest efficiency index will be retained.

(*c*) Those who wish to be released will be selected on the basis of adjusted service scores.

Dental Corps

(*a*) Officers whose services are essential to military necessity will not be separated from the service.

(*b*) Officers above 50 years of age whose specialist qualifications are not needed within the Army will receive high preferential priority for release from active duty.

(*c*) Adjusted service ratings will be utilized as a definite guide in determining those who are to be separated.

Army Nurse Corps

(*a*) All nurses whose husbands have been released from active duty will be discharged on request when release of husband is proved.

(*b*) No officer will be separated whose services are essential.

(*c*) Officers with children under 18 years of age who wish to be released will receive a high preferential priority for selection.

(*d*) Adjusted service scores will govern other cases.

Medical Department Dietitians and Physical Therapists

(*a*) All Medical Department dietitians and Medical Department physical therapists whose husbands have been released from active duty will be discharged on request when release of husband is proved.

(*b*) Military necessity will govern all others. Since there is a shortage of these officers, it is not contemplated that others will be released from the service except in *a*.

Veterinary Corps

(*a*) Since there are insufficient officers to meet the present requirements, it is not contemplated that any officers will be released from the service.

Sanitary Corps

(*a*) Officers whose services are needed will not be separated.

(*b*) Officers who express a desire to stay on duty shall be allowed to do so if vacancies exist. In the event there are more wishing to stay than there are vacancies, those with the highest efficiency index will be retained.

(*c*) Those who wish to be released will be selected on the basis of adjusted service scores.

★ ★

POSSIBLE RELEASE OF DOCTORS AND DENTISTS FROM ARMED FORCES

Major Gen. George F. Lull, Deputy Army Surgeon General, has estimated here that 2,000 to 3,000 doctors and several hundred to 1,000 dentists should be available for discharge from the Army by the end of this year. General Lull said the peak load on the Army Medical Corps will be reached in the fall. He explained that the wounded must still be transported home from Europe and soldiers scheduled for redeployment or discharge must be given physical examinations. He expects that most of the doctors and dentists released will return to civilian practice. The Veterans Administration has sought medical men, but its most urgent requirements were met by assignment of about 300 medical officers to the agency, he said. Most of these were assigned last year on active status, and 112 had previously served with the Veterans Administration. However, no Army doctors are now being assigned to the Veterans Administration unless they desire it. General Lull said that "as the size of the Army is reduced under the partial demobilization plan, it will be possible to release certain numbers of doctors and dentists. However, the shrinkage in the

number of medical officers will not be in proportion to the reduction of the Army as a whole, since the Army will still have many wounded in hospitals. Moreover, we never filled our quota of 48,000 doctors, as only about 45,000 were obtained. Dental officers number about 15,000. We probably can release 2,000 to 3,000 medical officers and a proportionate number of dental officers by the end of the year."

★ ★

GENERAL BRADLEY TO TAKE VETERANS ADMINISTRATION POST AUGUST 11

Although he conferred with members of the House Veterans Committee on proposed veterans' legislation and has already started a study on how to correct shortcomings in the administration of veterans' hospitals, General Bradley has returned to Europe to serve in the absence of General Eisenhower. He will take over as Veterans Administration chief about August 11. Meanwhile Committee Chairman Rankin has reported that hearings on proposed legislation to reorganize the medical staff of the Veterans Administration will be postponed until General Bradley returns. "We will continue with the investigation to have a full record for General Bradley and the committee," he said. "It will serve as a basis for corrective legislation." Before adjournment the committee heard Col. Louis Verdel, manager of the veterans' hospital at Northport, N. Y., where it was alleged that the Army had assigned physically and mentally unfit soldiers to attend mental patients, deny that Northport was the worst hospital in the service. He claimed that two of five army doctors attached to the institution were on prolonged sick leave, one of them diagnosed as neurotic by army examiners. "Maybe we'd better investigate the War Department," said Mr. Rankin. "I bitterly resent the War Department's attitude toward these veterans' hospitals."

★ ★

NEW BRANCHES CREATED IN PROFESSIONAL DIVISION

Vice Admiral Ross T. McIntire, Surgeon General of the Navy, recently approved a reorganization of the Medicine and Surgery Branch of the Professional Division creating two branches of the specialties, namely a Medicine Branch and a Surgery Branch. Capt. F. R. Hook (MC), U.S.N., will head the Surgery Branch, and Comdr. J. R. Miller (MC), U.S.N.R., will head the Medicine Branch. The latter branch is composed of a General Medicine Section and a Tropical Medicine Section.

Functions of the Professional Division are defined as follows:

"The Professional Division shall (*a*) consult with medical activities ashore and afloat in order to determine the professional needs and problems arising in the field; (*b*) study, evaluate, advise and make recommendations on the professional needs, policies, standards, practices and performances of the Medical Department, particularly as these relate to medicine, surgery, neuropsychiatry, rehabilitation and hospitalization, and (*c*) maintain liaison with such other military and civilian agencies as may be required in the prosecution of the functions of this division. The term 'professional' as used is interpreted to include all phases of clinical practice as well as the technical services and facilities required to make such practice effective."

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PENICILLIN SHORTENS CONVALESCENT PERIOD

According to a recent release from the U. S. Army General Hospital at Camp Pickett, Va., penicillin shortens by three to six months the average convalescence of American soldiers with limbs shattered by shrapnel or bullets in World War II. Lieut. Col. J. S. Norman, chief of the orthopedic service at Camp Pickett, stated that several million units of penicillin is administered during every twenty-four hour cycle to from 300 to 500 soldier patients. In many cases the penicillin treatment had begun immediately after a soldier was carried from the battlefield. From then on, at base hospitals overseas and on through treatment of the soldiers at army general hospitals in the United States, expert administering of penicillin continues. Almost without exception, infection is vanquished. Thus, surgery to mend shattered bones is rendered much easier and final healing itself is expedited.

Colonel Norman also stressed the improvement of other technics concerning treatment of smashed bones. In addition to the steady advance of hospital science as a whole picture, he pointed out that rapid development of traction devices and scientifically designed orthopedic braces play indispensable roles in the knitting back to normal of our fighting men's shattered limbs.

★ ★

ARMY ENROLLS FULL QUOTA OF OCCUPATIONAL THERAPISTS

Mrs. W. C. Kahmann, chief of the Occupational Therapy Branch of the Army Medical Department, recently announced that occupational therapists' emergency training courses will be terminated as soon as those courses scheduled for June and July have been completed. The courses were initiated last July to overcome a serious shortage of occupational therapists in army hospitals. The full quota of students has now been enrolled, and no further application will be considered. Under this emergency training program 700 college women were enrolled and on completion of their schooling will assist in the reconditioning of army sick and wounded soldiers.

★ ★

EXTENSION OF POLICY ON PROVIDING PROSTHETIC APPLIANCES

Veterans Administrator Hines has announced in a letter to all agency stations that the policy has been extended on provision of supplementary or emergency limbs to include braces and other types of prosthetic appliances. How many veterans will be affected cannot be estimated. The Army alone has reported 8,470 leg amputations and 2,530 arm amputations. The Navy has not issued comparative figures. The number of veterans who will require other types of prostheses or artificial limbs is said to be entirely "problematic."

WHOLE MILK FOR PATIENTS ON HOSPITAL SHIPS

The War Department recently announced that a new method of quick-freezing whole milk is now making it possible to serve this beverage to wounded soldiers returning from overseas on Army hospital ships. This welcome and important addition to the diets on the hospital ships resulted from a series of researches carried out by the Veterinary Division of the Office of the Surgeon General.

Although the milk in some instances has been kept in the frozen state for three months, its taste is as fresh as if it had just come from the cow and the bacterial count is lower than that in the average milk supply of the average American home.

Approximately 30,000 pints of frozen whole milk is now being shipped monthly from Charleston and Boston, and additional large amounts from New York, New Orleans, San Francisco and Seattle.

While the milk is intended for the hospital ships, some of it, when the situation makes it possible, will be sent to overseas hospitals as well. Later it is expected to enlarge shipments for the hospitals. In addition, 400,000 pints is being shipped monthly to Alaska for the general use of American troops stationed there.

★ ★

GERMANY'S TECHNIC IN SURGERY LAGGING

Germany, once the world's acknowledged leader in surgery and medicine, is twenty years behind American methods in the handling and healing of war wounded, according to Col. Edward D. Churchill, Allied Mediterranean forces' surgical consultant, who recently inspected the wounded in former German hospitals. A German army colonel indicated that he regarded the outcome of wounds in this war to be identical with conditions he observed in the first world war. American recoveries, on the other hand, improved phenomenally, such as field operating tents up at divisional clearing stations, the highly developed use of blood transfusions and the high standard of antisepsis in the field.

In the six German hospital areas inspected by Colonel Churchill he found that of forty serious chest wounds picked at random thirty-seven showed infection, while the American patient's average was well below 10 per cent. For blood transfusions the Germans used an antiquated syringe type apparatus discarded years ago by the Americans. The Germans had not realized the possibilities of transfusion and would not believe, until the Americans gave a demonstration, that one man could successfully receive more than 600 cc.

The fundamental difference found between the American and the German system is that the Americans have a systematic, continuous routine from the moment of wounding until the highest possible degree of restoration to health. Infected chest wounds, which after the first world war left hundreds permanently hospitalized with great gaping wounds, can now be handled so that within a few weeks the men are completely restored with normal respiratory systems. The Germans' methods, on the other hand, were characterized by a lack of direction or any general and definite policy in professional methods. Colonel Churchill stated that individual surgeons carried on "just about as they pleased" and field surgeons were inclined to pass over extremely serious cases with the idea that the injured men would die anyway.

★ ★

LOCAL APPLICATION OF CRYSTALLINE SULFONAMIDES DISCONTINUED

The War Department Technical Bulletin of Medicine (TB MED 147), March 1945 (distributed to general and field hospitals and other medical units), announced the general policies regarding the local use of chemotherapeutic agents. Experience in wound management justifies the abondonment of local use of any chemical agent in a wound for its supposed antiseptic effect in the prevention or treatment of infection. The practice of routine local application of crystalline sulfonamides to wounds as an emergency aid measure and prior to initial wound surgery will be discontinued. The local application of these compounds to wounds not involving serious cavities following wound surgery will also be discontinued, and their local use in wounds involving seripus cavities is not recommended.

★ ★

FIGHT DISEASE IN GERMANY

American personnel, displaced persons and German prisoners of war are being safeguarded against communicable diseases and tuberculosis under a sanitation program directed by 5th Infantry Division medical officers in that part of the Ruhr controlled by the 5th.

Lieut. Col. Enos G. Walker, Detroit, division surgeon, and Lieut. Col. Howard H. Base, commanding officer of the 5th Medical Battalion, are directing the sanitation program for Allied personnel, the division's three displaced persons camps and seven Allied prisoner of war camps. By installation of an adequate diet and sufficient sanitation and medical facilities, the 5th Division team has cut the death rate 65 per cent a day in one prison camp.

About 75 persons are evacuated each day in the Hemer prison camp, Colonel Walker said. Of this number about 65 prisoners are suffering from dysentery and 6 from typhus. Small hospitals are being established in the vicinity of prison camps.

Guarding against the spread of typhus the division medical group is delousing thousands of displaced persons daily through use of DDT powder. Allied medical personnel are being assisted in prisoner of war camps by German medical units which have set up their own dispensary facilities, using American supplies and working under 5th Division supervision.

Buildings in the 5th's area of control are being sprayed with DDT powder to destroy breeding places of the typhus carrying louse. In addition to other precautions, men of the division are being educated to take precautions against being bitten by the lice because typhus inoculations are not 100 per cent preventive against the disease.

Original Articles

CARCINOMA OF THE LARYNX: Present Concepts of Diagnosis and Treatment

PAUL H. HOLINGER, M.D.
CHICAGO

Cancer of the larynx is one of the most curable of all cancers. Unlike many other cancers, its onset is not silent but becomes apparent at once to the patient, his family and his physician. A change in voice or a persistent, progressive hoarseness is the danger signal. Fortunately, this symptom presents itself early, at a time during which the lesion may easily be removed. Unfortunately, early, it is painless and usually causes the patient little inconvenience; therefore, the patient postpones seeking a diagnosis until the more serious later symptoms of pain, dyspnea and dysphagia appear. Because of these factors, it would seem that an educational program such as that which has made the public aware of the importance of a small mass in the breast could now be directed toward a realization of the significance of hoarseness. As Clerf[1] has stated, "In this day, when there is so much time, energy, and money being spent to discover the cause of cancer, it behooves every one of us at least to detect its presence, especially where it can be so effectively treated."

Diagnosis. — The final diagnosis of carcinoma of the larynx can only be made from the microscopic examination of tissue taken from the lesion itself. The gross examination is never absolutely diagnostic. Papillomata, leukoplakia, and, in some instances, the fungus infections or tuberculosis of the larynx may so closely simulate the gross appearance of laryngeal carcinoma that only the gravest tragedies can follow initiation of surgical or irradiation therapy without histologic confirmation of the diagnosis. In spite of this well known fact, instances of such management are still too frequently seen. Aside from the gross mismanagement of the patient, such cases introduce serious errors in statistics which attempt to evaluate the effect of various therapeutic procedures.

The diagnosis of laryngeal carcinoma begins with the history, which is usually that of hoarseness of several weeks' to several months' duration, with pain, dysphagia and dyspnea as later symptoms. Persistent, progressive hoarseness in adults must be considered due to carcinoma until careful studies have confirmed or denied this diagnosis. The mirror examination of the larynx, always a preliminary one, gives the first positive clue. But often the gagging patient prevents a satisfactory examination from being made, or an overhanging epiglottis hides the area of vocal cords in which early carcinomas are most frequently found. This examination is facilitated in the gagging patient by spraying the pharynx with 2% pontocaine or 5% cocaine to eliminate the gag reflex. With this anesthetic the overhanging epiglottis may be retracted by a curved applicator, and the entire larynx inspected at leisure, noting the position and extent of the lesion, as well as the motility of the vocal cords.

The roentgen examination of the larynx is the second step in the diagnosis of carcinoma of the larynx. This includes the usual lateral x-ray

Presented before the Section on Eye, Ear, Nose and Throat, 104th annual meeting, Illinois State Medical Society, May 16-18, 1944.

From the Department of Laryngology, Rhinology, and Otology, University of Illinois College of Medicine, and St. Luke's Hospital.

of the neck for soft tissue outlines and an antero-posterior film to outline the trachea. The antero-posterior laryngeal examination made by placing a film in the esophagus aids greatly in outlining the subglottic extent of a lesion. Finally the planogram, in focus at various levels from front to back, often gives additional information regarding the invasion of the tumor into the deep structures of the larynx.

The removal of tissue for biopsy is the most important of the diagnostic procedures. This may be done indirectly, but the direct examination with the laryngoscope permits more satisfactory search of the laryngeal ventricles and a more complete examination subglottically. The careful study which the direct laryngoscopic examination affords makes more certain the removal of representative tissue for biopsy and aids in designating therapy. Too much stress cannot be placed upon the establishment of the diagnosis accurately by biopsy. This is re-emphasized here because cases still come under observation that have had therapy for a supposed carcinoma but have never had a biopsy. Subsequent examination demonstrated two such cases to have laryngeal papillomas and two others to have laryngeal tuberculosis. It is especially regrettable that these patients had received their therapy in an institution that reports its cases as biopsy-proved.

Histologic gradation of a tumor of the larynx as a criterion for the selection of therapy is stressed by some and condemned by others. While different grades of tumor activity may be found in the same tumor at different sites, one rarely finds a grade I and a grade IV type in the same lesion. Consequently, the gradation of malignancy plays a part in determining the therapeutic procedure to be chosen in certain borderline cases.

Thus, in the diagnosis of a carcinoma of the larynx one must determine its location and extent grossly, the degree of motility of the vocal cord, and finally the histopathology of the lesion.

Treatment. — The therapy of laryngeal cancer has undergone frequent changes and has passed through many cycles. Evaluation of a therapeutic procedure should, it would appear, be judged on the basis of a *permanent* cure of the disease rather than on the basis of a five-year cure or even, as has recently been done, on the basis of a three-year cure. It is a well known fact that carcinomas of the larynx surviving the first year or year and a half after treatment recur most frequently in the fourth and seventh years. Therefore, a true analysis of the effectiveness of treatment cannot be made with patients who have not passed these critical years.

Surgical procedures in laryngeal carcinoma may be divided into three groups: direct endoscopic procedures, laryngofissures, laryngectomies. Direct endoscopic procedures, the most conservative, are suggested in only a very limited group. Jackson and Jackson[2] mention this procedure as a wide resection of a small lesion with punch forceps. Le Jeune[3] and Figi[4] have suggested a similar procedure with cautery dissection under suspension laryngoscopy.

Without question, the laryngofissure operation has given the highest incidence of permanent cures of carcinoma of the larynx of any therapeutic procedure. This conservative surgical resection of one vocal cord is indicated when the lesion is localized to the middle third of the cord and has produced no impairment of motility. If the lesion occupies the anterior commissure, the anterior third of both vocal cords can be removed by the laryngofissure technic. Thus, the carcinoma is removed, the original airway preserved, and the patient is provided with a serviceable voice. Series of cases showing an 86% cure of these early, localized cases by the laryngofissure technic have been reported.[5] Our own small series of 20 cases cannot be fully presented at this time since we feel that sufficient time has not elapsed to give proper significance to these cases. However, only one of the 20 cases has developed a recurrence. One of these cases was operated more than five years ago and ten more than three years ago. The recurrence in the one patient mentioned developed within 6 months of the original operation. Considering this a curability rate of 95% is not justifiable until sufficient time has elapsed to be positive all cases are stable.

In the more advanced lesions, if the carcinoma is still within the confines of the glottis or shows only moderate subglottic extension, it is evident that surgical removal of the larynx, total laryngectomy, gives the highest incidence of cure. This incidence, 50% to 60%, is below the rate of cure for either surgical or irradiation

therapy of the earlier lesions described above. Again reporting only preliminarily our own cases, of 19 laryngectomies 12 are living and well, free of recurrence, and one died at 76 years of age 7 years after surgery, of cardiac decompensation but free of carcinoma. Five patients have developed recurrences. The 19th patient, one of the earliest in the series, died 3 weeks following surgery. It is emphasized again that this group has not been under observation a sufficiently long period of time to regard the statistics as any more than a preliminary report.

More extensive extrinsic carcinomas[6] of the larynx are generally considered inoperable and the results following surgery are unsatisfactory in most instances. However, the brilliant results achieved with this group by Orton[7] point the way for increasing the indications for radical surgical procedures.

In a discussion of present concepts of treatment of carcinoma of the larynx, advances in surgical technic may be presented in some detail. Preoperatively, both before laryngo-fissure and laryngectomy, careful attention to dental hygiene is of utmost importance. Postponement of surgery for a week to ten days to permit necessary dental work to be done results in a marked improvement in post-operative time and a reduction of post-operative infections. The administration of sulfa drugs, beginning two days prior to surgery, likewise aids in reducing post-operative infections to a minimum.

The advent of intratracheal anesthesia has aided materially in reducing the hazards of operation in our series of laryngectomies. We have, for a number of years, employed the technic recently described by Browne,[8] using an intra-tracheal tube passed into the trachea through the nose or mouth during the skeletonization of the larynx.[9] This is replaced by an "anode" tube placed into the trachea by the surgeon after the larynx is severed from the trachea. An inflated cuff attached to this tube prevents the aspiration of blood from the wound, and likewise keeps the field free of tracheal secretions since these are aspirated by the anesthetist with a small catheter inserted occasionally through the anode tube itself.

A major contribution in the surgical technic of the laryngectomy operation has recently been suggested by Vasconcelos and Barretto[10] of Sao Paulo, Brazil. This consists of the adoption of a surgical principle long used in gastric surgery to the removal of the larynx. Following skeletonization of the larynx a specially constructed curved clamp is passed under the larynx at its attachment to the pharyngeal mucosa. The larynx is then removed by severing it from the upper surface of the clamp and the pharyngeal mucosa is sutured without opening the pharynx. The employment of this technic results in a primary closure of the wound without a fistula. The feeding tube may be removed on the third to the fifth day, and the patient is able to leave the hospital on the eighth day following the laryngectomy.

Advances in the technic of irradiation have increased the usefulness of this therapeutic procedure. In early cases of intrinsic carcinoma, however, there is as yet no recorded evidence that this type of therapy can approach the rate of curability obtained surgically in a similar group of cases over a reasonable period of time. However, irradiation is indicated in cases in which surgery is contraindicated by the age, physical condition or the temperament of the patient. In the extrinsic or inoperable lesions increasingly good palliative results as well as an increasing incidence of five-year cures may be expected with improvement in technic. A third type of carcinoma of the larynx for which irradiation is indicated as a choice of therapy is the tumor that grossly has extended to the borders considered as the limitations for surgery, yet histologically is demonstrated to be a grade III or grade IV tumor. Such lesions respond exceedingly well to irradiation, but their rate of recurrence is relatively high.

Always of importance in the evaluation of therapy is the preservation of function. This must be entirely secondary, however, and never advanced as a primary consideration. Preservation of voice for a year or two at a sacrifice of life at the end of that time cannot be justified. The voice after irradiation is admittedly best of all, provided the tumor was not too large and the lesion was relatively radio-sensitive. The voice after laryngofissure is usually good, and in some instances returns to an essentially normal character. The development of bucco-esophageal speech following laryngectomy, or the use of an artificial larynx, permits the patient who has

had this type of surgery to converse satisfactorily. Improvements in teaching the technic of bucco-esophageal speech will make it supplant the use of the artificial larynx.

CONCLUSIONS AND SUMMARY

1. Cancer of the larynx is one of the most curable of all cancers. The diagnosis can be made and appropriate curative treatment can be instituted early because the initial symptom, hoarseness, is an early one.
2. The diagnosis can only be made by biopsy. The history, mirror examination, roentgen delineation and direct visualization aid in establishing the extent of the lesion.
3. The histology and site of the lesion and the general condition of the patient determine treatment. The ultimate prognosis is best in well differentiated lesions.
4. Laryngofissure with cord resection of well localized lesions in the middle third of the cord or in the anterior commissure or the rare endoscopic resection of extremely small lesions will result in curing 85% of patients with this type of lesion.
5. A laryngectomy is indicated in cases of intrinsic lesions in which the tumor extends to the arytenoid and impairs its motility, or extends slightly subglottically. Laryngectomies will result in curing 50% to 60% of these cases.
6. Irradiation of early, intrinsic lesions limited to the vocal cord without impairment of motility has not shown the ability to give results equal to surgery in similar lesions. However, irradiation is indicated in these cases if the age or physical condition of the patient contraindicates surgery.
7. Irradiation of the more advanced intrinsic lesions and the extrinsic lesions is showing a steady improvement in the results of therapy. In borderline cases the grading of the tumor is significant in determining therapy.
8. In the management of laryngeal carcinoma the cure of the cancer is of primary importance. The return of function is secondary and should not be a determining factor in the choice of therapy. The voice after laryngofissure is usually good; the bucco-esophageal voice or the artificial larynx is serviceable and places little limitation on the patient's activity.

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DISCUSSION

Dr. Thomas C. Galloway, Evanston: I can disagree with nothing Dr. Holinger said. I think that most men who are interested in this particular field have pretty well standardized their ideas and have come to rather definite agreement along the lines the speaker outlined. It is unfortunate this presentation was given before this audience rather than before a group of men in general practice, because there are certain approaches to treatment of carcinomas of the larynx which they should know.

Our head cancer team at Cook County Hospital consisting of clinician, pathologist and radio therapist has seen great advances in the treatment of cancer in the last twenty years. In some types, as for instance in carcinoma of the pharynx and the tonsil, I have swung very sharply from surgery and believe that in these particular instances the preferable treatment is irradiation. But when we come to discussion of carcinoma of the larynx, both surgery and irradiation must be considered, as Dr. Holinger has so carefully outlined, on the basis of type and location.

We have heard a great deal lately about the value of irradiation in the larynx. I have been skeptical of some reports because later we have had to take some of these patients favorably reported on and furnish them free beds at the County Hospital until they die. I have seen three patients die—one from irradiation necrosis and two from recurrence—within six months of the time they had been demonstrated as cured. It is generally held that five year cure is a proper criterion. One of the best reports is that of Coutard showing 28 per cent cures of 5 year freedom from recurrence, and Coutard subsequently issued a very honest report showing that one-third of the 28 per cent died of recurrence in the sixth or seventh year.

When we see reports of three year cures on which we are to compare treatment as opposed to the very satisfactory treatment by surgery, especially in that

type of intrinsic carcinoma of the cords which will recover in 85 per cent of cases with a normal airway and useable voice, I think there is a marked injustice done to the patient. He is given the hope that without suffering any loss of time, or undergoing any danger, he can have simply irradiation and be cured, which is far from the truth.

It is true that if a man has a new method which he thinks is going to revolutionize treatment he may present it even only after three years of use so that others may try it. But we should hold ourselves to fair criteria and get it to the people who see such cases first that statistics must be fair and based on biopsies, and sufficient time must have elapsed so that we can be sure the results are going to be permanent before they are published as definitive results.

Dr. Danley P. Slaughter, Chicago: I should like to congratulate Dr. Holinger on this paper. I think it presents a very clear concept of the problem.

I think one of the main problems in the cure of larynx cancer is the extension of the use of laryngofissure. Too often some of us try to make these operations do what they were not intended to do and that is why they have fallen into some disrepute. If the indications are definitely adhered to, the operation of laryngofissure is alright, but in the attempt to save the voice we are likely to stretch the indications. The problem of metastatic cervical nodes from larynx cancer should be entirely a surgical one in those cases in whom serious attempt to cure is done. Most recurrences following laryngectomy occur in the neck nodes, which actually is one reason for laryngectomy. Following such an operation there is no larynx for the cancer to recur in. When squamous carcinoma does occur in neck nodes the treatment should be radical neck dissection if the nodes are operable. Such tumors are by no means as curable by radiation methods as by complete surgical excision. By radical neck dissection I do not mean a removable of one or two nodes but rather a formal operation designed to remove all the lymphatic tissue in the neck including the internal jungular vein and the sternomastoid muscle. It is impossible to do a complete neck dissection without removing these last two structures.

Dr. Holinger has had recently two cases from his series who have had neck node recurrences. I have had the privilege of doing radical operation on both. Although both are recent cases they are both doing well at the moment and are certainly in far better condition than they would be from treatment by radical radiation. The presence of one or two metastatic nodes, if still operable, is no contrary indication to laryngectomy if the primary lesion is still operable. In such cases both operations should be either at the same time or postponing the neck dissection for an interval of three to four weeks. In border-line cases it is possible to use radon seeds to keep the nodes under control temporarily until operation can be done.

Dr. G. H. Scott, Chicago: I would like to ask one question. In the matter of postoperative irradiation, do you believe that a cancer which you consider operable should be irradiated after the cancer has been removed to your satisfaction? Or do you think it is better to wait until you see signs of recurrence before considering irradiation?

Dr. Paul H. Holinger, Chicago (closing): In answer to the last question, I believe that so-called prophylactic irradiation following surgery for cancer of the larynx should not be administered unless it was found during the surgical procedure that the lesion could not be completely removed. In other words, we would prefer not to give any irradiation after surgery unless positive evidence of a recurrence was found. Thus, one would hold the fire until it was needed.

I wish to thank both Dr. Galloway and Dr. Slaughter for their discussions. Both were very important and added immeasurably to the paper. As Dr. Galloway stated, while presentation of a paper on cancer of the larynx before this group is important, this subject should be discussed before a general session. Division of a state meeting such as this into sections has its disadvantages. The purpose of a paper such as this is to stress the significance of a symptom, hoarseness, for which the patient first seeks aid from his family doctor. Hoarseness should be popularized as a symptom of significance suggesting systemic disease in the same manner that a cough has been looked upon as a symptom requiring an extensive search for its cause.

I am glad that Dr. Galloway emphasized two additional points: First, the question of "three year cure" which in cancer of the larynx is no real cure, and, second, the question of the need for honesty in reporting statistics. To report a case of cancer of the larynx as a cure only to have the patient die of his cancer a few months later or to report a case of cancer of the larynx supposedly cured which in truth on biopsy had been a papilloma introduces errors in evaluating therapeutic measures that will take years to correct.

INCIDENCE OF PERFORATED ULCER LOW

The total incidence of perforated ulcer, the most serious complication in this stomach condition, is substantially small, it is reported in *The Journal of the American Medical Association* for June 9. Only about 8 per cent or less of the ulcers, according to figures cited, perforate or penetrate the tissues. The figures cannot be considered definite, however, since the number is dependent on two variable factors, the activity of the ulcer and the period of time under consideration. The possibility of perforation can be reduced to a minimum by adequate treatment of the ulcer until healed, by continuation of an ulcer diet to prevent recurrence and by examination at regular intervals.

TREATMENT OF SUBACUTE BACTERIAL ENDOCARDITIS, RECOVERY WITH PENICILLIN

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The outlook for patients with bacterial endocarditis is unfavorable. Its treatment can be divided into two eras: that preceding and that subsequent to sulfanilamide and penicillin.

Prior to sulfanilamide reports of cures were rare. Even those of competent clinicians were regarded skeptically. Many authorities looked upon such reports as instances of rheumatic endocarditis, a type characterized by its tendency to heal or at least by a disposition to remit. The distinction between acute and subacute or between rheumatic and subacute or bacterial endocarditis may not be obvious. Clinically the much greater likelihood of emboli and the isolation of streptococci from the blood have been taken as the most important marks of subacute bacterial endocarditis as differentiating it from the rheumatic type. Arthritis common to rheumatic fever is not a part of subacute bacterial endocarditis. Active rheumatic fever endocarditis and subacute bacterial endocarditis may coexist. 10-20% of patients with rheumatic heart disease terminate with subacute bacterial endocarditis.[1] Without adequate bacteriologic facilities it has not been possible to properly identify a given instance of non-embolic endocarditis. On the other hand it has been thought that very painstaking bacteriology yields bacteria even in rheumatic endocarditis.[2]

The outcome of the disease has itself been taken as a diagnostic criterion. If an endocarditis patient recovers, his recovery has been taken to indicate that his endocarditis was rheumatic. Libman assumes that all "recoveries" antedating sulfanilamide and artificial fever were spontaneous remissions and numbered about 3 cases in each 100. Among these are the oft-quoted patients treated by Capps with intravenously injected cacodylate.[3]

Of the 7 cases recently reported by Kelson and Paul White[4] as treated by sulfapyridin and heparin, 3 were made symptom-free. Of these successes only one showed emboli. 3 of the failures had emboli. While emboli may not mark subacute bacterial endocarditis from rheumatic endocarditis they certainly distinguish the process as being more serious.

This overlapping of findings and difficulty in the clinical distinction of rheumatic from bacterial endocarditis carries over into the pathology. Competent, unprejudiced pathologists as Clawson[5] have used the greater frequency of emboli, bacteria in the blood stream, the softer type of vegetation and the less common incidence of Aschoff bodies in bacterial endocarditis as the findings marking it from rheumatic fever.

The reported finding of active inflammation in the hearts of patients dead of cardiac failure many years after their acute carditis emphasizes the need for conservatism in speaking of cure rather than remission in discussing infections of the heart.

Eggleston thinks that all cures for as short as six months time must be rejected as remissions.[6] After the advent of bacteriology vaccines were employed in the treatment of endocarditis.[7, 8] As recently as 1934 cures have been reported by this method.[9] Indeed, vaccines have been advocated to reinforce the sulfa drugs.[10] Arsenic as cacodylate or arsphenamine was the earliest form of chemotherapy. Mercury, in the form of merthiolate, followed. The results remained unimpressive. Although there were earlier reports of successful sulfa treatment of acute bacterial endocarditis cures of subacute endocarditis, the lenta form, appear after 1937. All of the forms of sulfa have been employed. The only effect was a lower temperature which resumed its former height on stopping the sulfa. An average blood level of 12 g. was maintained. To the sulfa therapy was added heparin,[12] now discontinued, and fever produced electrically or by intravenous nonspecific vaccines. With some reports optimistic[4, 13] failures predominated and most investigators had no success even with continued, heavy doses in many cases.[12, 14]

The discovery of penicillin naturally led to its use in endocarditis; this in spite of its demonstrated ineffectiveness against most strains of streptococcus viridans in vitro and in experimental infections of animals and also in spite of the discouraging report of Keefer's committee governing the early distribution of penicillin. In my experience the nonhemolytic streptococcus found in the blood of patients with subacute bac-

terial endocarditis is usually classifiable as streptococcus fecalis (enterococcus).

Poindexter claims that streptococcus salivarius is the strain of streptococcus most commonly found in endocarditis lenta.[15] According to him streptococci of the salivarius group are more susceptible to penicillin than are the enterococci or bovine strains.

Two of my patients were treated with vaccine, one with vaccine and sulfa and one with penicillin following unsuccessful sulfa therapy.

CASE HISTORIES

Case 1. Female, 25 years old in 1934 complained of recurrent sore throats, a knowledge of "heart disease", a shortness of breath and sore joints. Had had repeated sore throats since childhood culminating one year before examination in a "streptococcus infection" with high fever and sore, swollen joints lasting several weeks. "Heart murmurs" were found several years ago. She had been short of breath for one year. Her joints were painful and tender when first seen.

The essential findings were anemia, petechiae about elbows and wrists, tachycardia, low fever, enlargement of the heart to the right, variable presystolic murmur and a palpable spleen. Cultures of her blood according to Clawson's method yielded indifferent streptococci becoming green on repeated subculture. After 25 injections of a vaccine made from greening streptococci isolated from her throat she was fever-free. Pain left her joints. Her blood was sterile. The spleen could not be felt. The heart was unchanged. After 7 years these findings remained as on last examination. There had been no recurrence of joint pain. This patient may have had streptococcemia complicating rheumatic fever and rheumatic endocarditis.

Case 2. A nurse, 27 years old, complained of fever, cardiac irregularity and precordial pain. She had had frequent severe attacks of tonsillitis until a tonsillectomy 17 years ago. She had scarlet fever 11 years ago and acute iritis 6 years ago. 3 years before the present illness she had had sore throat followed by substernal pain, transiently swollen painful joints and fever for several weeks. A streptococcus vaccine had been given at that time.

Her present symptoms had started 7 months before examination with fever of 99.0-100.0. Her heart "flip-flopped." Petechiae were noted, the heart was found enlarged. There were variable cardiac murmurs. The spleen was enlarged. Her feet swelled during the day and a diagnosis of acute endocarditis was made. She had then been sent to bed for 6 weeks. 6 teeth had been extracted 3 months ago.

In spite of the extreme exhaustion and afternoon fever she refused to stop work. Night duty in an institution permitted her some rest. She was cyanotic. Her temperature was 99.6 degrees. Her heart was enlarged transversely. There was a presystolic and a systolic apical murmur. The first tone at the apex was accentuated. The pulmonic second tone was accentuated and duplicated. The liver was 2 fingers below the costal margin and tender. The spleen could be felt. I saw no petechiae. Her hemoglobin was 75%, erythrocytes 5,000,000 and the leucocytes 8,700. She said that at no time in the 7 months had the leucocytes been increased. Indifferent streptococci were isolated by me from her blood on two occasions. These were identified as enterococci. She was under observation for 10 weeks taking hydrochloric acid for achlorhydria. Her condition remained unchanged. Fever persisted. 34 subcutaneous injections of a stock vaccine containing greening, hemolytic and indifferent streptococci of blood origin were given over 14 weeks. These doses ranged from 20,000 to 1,000,000,000 bacteria, general reactions being avoided. Two cultures of her blood yielded no growth. The liver and spleen could no longer be felt. Five years later she remained well. Her heart findings were unchanged.

Case 3. A nurse, 33 years old, had been tired and chilly for 6 months. She had had scarlet fever and recurrences of hemolytic streptococcus sore throat. 12 years ago she had arthritis with swelling, pain and fever for 6 months. A mitral stenotic lesion had been found later. For 9 years she was very well. During the last 6 months she had chilly sensations and was exhausted. Three weeks ago she had had a rigor and a fever of 103.0 degrees with a "streptococcus sore throat." The fever persisted. Her leucocyte count was 19,000. A physician said she had "bad endocarditis" and gave her a course of 7 grams of sulfanilamide. The fever became lower and the leucocyte count dropped. Her heart was enlarged to the right. There was a soft systolic murmur. Her hemoglobin was 84%, erythrocytes 4,150,000 and the leucocytes 9,950. Sedimentation in one hour was 20 mm. There was no petechiae. The liver and spleen could not be felt. Two blood cultures according to a modification of Clawson's method yielded indifferent streptococci. She was given complete bed rest in a hospital for 4 weeks. During this time she received sulfanilamide, 3g. daily, and at first a stock vaccine of indifferent enterococci, then a vaccine of streptococci from her own blood. The vaccine was given subcutaneously in subreaction doses. Blood cultures were sterile after 6 weeks of this treatment. Her temperature became normal after 3 weeks' hospitalization. After leaving the hospital she remained home for 6 weeks administering the vaccine as directed.

She has remained well and working. She maintains a normal temperature and her blood is free from bacteria one year after being discharged from the hospital. Her heart findings are unchanged. Her sedimentation rate is 8 mm. in one hour.

Case 4. (Seen with Dr. W. B. Knox in the West Suburban Hospital.) O. M. was a woman 27 years old. She was a "blue baby," congenital heart disease being diagnosed at birth. Her grandmother and mother are said to have had congenital heart disease and rheumatic fever. The patient had rheumatic fever at 12 and again at 21. She has had a fever, progressive

weakness and palpitation for the last 3 months. 6 weeks ago she suddenly developed right hemiplegia and aphasia. The aphasis disappeared. Some voluntary movement of the right arm and leg have returned.

She had a typical "cafe au lait" color. Her fever was remittent, reaching 102° in the afternoon. The heart was enlarged transversely. The pulse was regular but rapid. There was an apical systolic murmur and thrill. The blood pressure was 95/55. The spleen was palpable. Petechiae were present in the conjunctivæ and about the wrists. The nails and lips were deeply cyanotic. The fingers were clubbed.

Hemoglobin was 88%, erythrocytes 4.73, leucocytes 11,100. The urine showed albumen. Numerous blood cultures showed large numbers of greening streptococci until April 10, 1944. She had had sulfathiazol, 4 g. daily for 3 weeks. She was also given 2 g. of gold sodium thiosulphate starting with 0.1 g. intravenously and increased by 0.1 g. at weekly intervals. A vaccine made from the blood streptococci was started April 7 without apparent benefit. 2,800,000 units of penicillin were given intravenously in 13 days terminating April 20, 1944. 700,000 units of the sodium salt of penicillin was dissolved in 1,000 cc. of the diluting fluid which was alternately normal saline and 5% glucose. The dose averaged 200,000 units daily in nearly continuous intravenous drip.

On the fourth day of the penicillin administration the bacteremia disappeared. Cultures of her blood as of Oct. 10, 1944 yielded no growth. The spleen was no longer palpable. The temperature became normal the third day after penicillin was started, went to 100° three days later and has since not exceeded 98.4. The hemoglobin on Aug. 30, 1944 was 89%, with erythrocytes 5,240,000 and leucocytes 9,000. The differential was normal except for an eosinophilia of 6%. The monocytes numbered 4%. The sedimentation rate is now 5 mm. in 1 hour.

COMMENT

That these patients had all apparently had rheumatic fever is quite in accord with the accepted concept of the evolution of bacterial endocarditis. Against the possibility of my patients having rheumatic endocarditis are the repeatedly sterile cultures obtained in my previous studies of patients with classical acute rheumatic fever.[16]

The bacteria isolated although not always greening were of low virulence corresponding in other bacteriological respects with streptococcus viridans. Whether streptococci are indifferent or greening is often only dependent upon the frequency and length of subculturing and of the mediums used.

The "cures" reported may be clinical rather than bacteriologic. Viable bacteria are frequently found in fixed tissue long after illness. It is sensible that the infections in endocarditis vary in virulence as their hosts vary in resistance. These variables give us instances of the disease differing in symptoms and course as well as in prognosis. Here may lie the reason for the dissimilar results obtained by other investigators and by us in the group studied personally.

The infections reported may have only been reduced from activity to latency.

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CHEMOTHERAPY

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Chemotherapy in association with new developments such as modern anesthesia, intestinal decompression, replacement of electrolytes and proteins has introduced a new era in surgery. If one compares morbidity and mortality rates for surgical procedure or treatment of traumatic wounds for a five year period before and after the advent of chemotherapy, one is impressed that a significant improvement has occurred. Under chemotherapy we will include only treatment with drugs of the sulfonamide group, penicillin, tyrothricine, azochloramid and zinc peroxide. Because of the wider use of the sulfonamides and the recent encouraging results with penicillin, these two groups will be discussed more in detail.

SULFONAMIDES

In spite of an enviable record we must not consider that the sulfonamides will do all the work for us, as too many might be led to believe from occasional experiences of a miraculous result. The sulfonamides are not a "cure-all" in any type of surgical infection, whether it is a traumatic wound or an operation in an infected area. The enthusiasm for chemotherapy should not lead one to neglect other principles which are fundamental in good surgery. The use of sulfonamides should not minimize the necessity of surgical asepsis. In the words of Graham, "The day of Listerism is not yet gone; the sulfonamides will not replace surgical asepsis."[1]

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Without minimizing the great advance that chemotherapy and the sulfonamides have given to surgery, it is necessary to warn against their being accepted as the panacea for all ills. It must be repeatedly stressed that chemotherapy is a valuable adjunct in surgical therapy but that it has its limitations and principles of good surgical judgment and technic must always be in the foreground in any surgical case. Moreover, as Meleney[2] pointed out, it is not justifiable in comparing statistics of surgical results of five years ago with those of the present day to give all the credit to sulfonamide therapy, since in the past few years various other factors came on the scene which have helped the surgical patient.

Meleney[3] furthermore stresses particularly the difference between surgical and medical infections regarding sulfonamides. Whereas in medical infections one deals with a condition which by its nature facilitates the contact and the action of the drug on the infective organism; in surgical infections the opposite frequently holds true. It is therefore necessary to recognize the predominant importance of surgical management and of the physiological factors in wound infection and wound healing in surgical infections, since in these chemotherapy is only of an adjuvant nature.

The sulfonamides can be used under any and all conditions although certain diseases do better with one type than another. Their administration is compatible with any type of anesthesia, they will not influence adversely other types of treatment nor will they affect the course and treatment of shock. They can be used prophylactically or therapeutically by oral, parenteral or local application.

ORAL USE. Most of the sulfonamides (sulfanilamide, sulfadiazine, sulfathiazole, sulfamerazine, sulfaguanidine and succinylsulfathiazole) can be given orally. If given early they do cut down the incidence of septicemea and death and may lessen the incidence of local infection. This observation has been made by many surgeons. The local use of sulfonamides should be supplemented by oral or parenteral administration. Sulfadiazine, sulfathiazole or sulfamerazine is the drug of choice for oral or parenteral use. Following 5 or 10 grams of either sulfanilamide, sulfathiazole or sulfadi-

azine intraperitoneally, oral or intravenous chemotherapy supplementally should not be started until the blood level indicates the need for further therapy and then treatment should be continuous until the patient has clinically improved as seen by the disappearance of temperature and general well being. Oral sulfonamides can be used for any condition in which sulfonamide therapy is indicated and in which the patient can take sulfonamides by mouth.

The average initial dose of sulfanilamide, sulfathiazole, sulfadiazine and sulfamerazine for an adult is 4 grams. Subsequent doses are 1 gram every four hours except in the case of sulfamerazine when the time interval may be longer (about 6 hours).

Bowel surgery has greatly benefited from the use of the insoluble sulfonamides (sulfaguanidine and succinylsulfathiazole). Both of them seem to decrease the number of coliform organisms in the intestine and the incidence of peritonitis following surgery of the large bowel. Sulfaguanidine should be given with caution when there is ulceration of the mucosa or when there is intestinal obstruction.

The action of sulfaguanidine or succinylsulfathiazole is impaired during diarrhea or constipation. Liquid petrolatum or other cathartics should not be used at the same time. In patients receiving sulfaguanidine or succinylsulfathiazole, the proper preoperative preparation consists of the omission of enemas, cathartics and petrolatum. The drug should be given in full doses and the optimal time for surgery should be judged by the bacterial counts on the stools. The drug could be given immediately after operation as soon as water is taken. It should be emphasized that succinylsulfathiazole and sulfaguanidine are only adjuncts to surgery of the lower intestinal tract and they should not be permitted to nullify observance of well established surgical principles in the pre- and post-operative care of such patients.

The dose for sulfaguanadine is 0.25 grams per kilogram of body weight divided in six doses for 24 hours. The dose of succinylsulfathiazole is 0.25 grams per kilogram of body weight as initial dose and then divided in 6 doses for 24 hours.

Phthalylsufathiazole, which is a new sulfonamide substance, promises to be useful in enteric infections.

PARENTERAL USE. The sodium salts of sulfadiazine, sulfathiazole and sulfanilamide can be given parenterally. The indications for parenteral use are inability of the patient to take sulfonamides orally or when a rapid blood concentration is desired. Five grams of sodium sulfadiazine at once or in two doses will suffice for 24 hours. Sulfathiazole should be given in about 2-gram doses every 6 hours to maintain appropriate blood concentration.

Subcutaneously, 0.8% of sulfanilamide has been used with success in streptococcus infections. Recently, the use of 0.5% sodium sulfathiazole or 1% sodium sulfadiazine has also been suggested for subcutaneous use.[4]

The increased solubility of acetylated sulfonamides in alkaline urine suggests the addition of alkali as good treatment. Two and a half grams of soda bicarbonate should be given with each dose of sulfonamides. Fluids should be forced so that a daily urinary output of at least 1500 cc. is obtained. Recently, the value of intravenous 1/6 molar soduim r-lactate in producing an alkali urine for sulfadiazine therapy has been shown.[5]

LOCAL USE. The local use of sulfonamides has especially come to the foreground since the enthusiastic reports from Pearl Harbor where the favorable results among the many casualties were ascribed to the free and general use of sulfonamides in wounds. Here too, however, one must not be misled by general enthusiasm but examine the indications critically. There are certain conditions which must be met in order to get the maximal benefit from the local use of sulfonamides. Fundamentally these conditions are based on the use of good surgical technic. Thus, the condition of the wound at the time sulfonamides are applied is of importance. Poorly debrided wounds are unsuitable for sulfonamide application. Necrotic material and pus contain large amounts of para-aminobenzoic acid which inhibit the action of sulfonamides and for that same reason wounds cannot be closed too tight as they will cause sloughing of necrotic material.

Thus far, sulfanilamide has proven itself best for local use because it is most rapidly absorbed and because a small crystalline structure causes less irritation than the other forms. Sulfanilamide is best for local use whether it is in various types

of external wounds or in the peritoneal cavity. To date its use intraperitoneally has not been associated with any untoward reactions in spite of its wide spread usage. It has definitely been effective in combating and minimizing peritoneal infection. From observations to date and from experimental results there does not seem to be any interference with wound healing by the local application of sulfanilamide. It may lead in some wounds to an increased serum production.

As stated above, sulfanilamide is easily absorbed regardless of the site. Sulfathiazole is less soluble, tends to cake and may create more foreign body reactions. It, however, is active against more organisms; hence, some surgeons prefer sulfathiazole mixed with equal amounts of sulfanilamide for local use. Waugh[6] believes that sulfathiazole may be the more valuable drug intraperitoneally following perforative appendicitis because it remains longer in the peritoneal cavity, it stimulates local cellular response and is a polyvalent anti-bacterial agent. Recently a micro-crystalline form of sulfathiazole has been recommended. Sulfadiazine can be successfully used intraperitoneally. It is less irritating than sulfathiazole, more effective and longer lasting.[7]

The dosage of sulfanilamide for local use as given by the National Research Council is approximately 0.1 grams per square inch although larger doses up to 20 grams may be instilled into larger wounds. More sulfanilamide may be instilled if the wound remains open. Some[8] including ourselves believe that the sulfanilamide should be frosted or sprinkled thinly into the wound and distributed evenly and uniformly. Others[9] feel that it is better to dump the sulfanilamide at the desired point rather than to spread it inasmuch as the dumping causes a high concentration at the desired area and it also prevents the possible spread of any infection present.

In civilian practice when sulfanilamide is used locally in compound wounds, the wounds may be closed primarily. In military cases, or in dirty wounds, it is best to permit closure by secondary intention. Exceptions to the latter are wounds of the abdomen, chest, hands or brain. It is important that hemostasis exists before sulfanilamide is applied since otherwise the drug is washed out from the wound and is prevented from actual contact with the contaminated tissue. Because of the beneficial results obtained from the local use of sulfonamides in infected wounds, some have advocated its use in any type of wound, even clean wounds, except in patients with facial lesions.

Ravdin and his associates state[10], "Peritonitis has become an infrequent occurrence in this clinic since the introduction of the prophylactic use of sulfanilamide." Waugh and others agree with that statement, although they feel that improvement in pre- and post-operative measures may have had quite a bit to do with it. Waugh[6] points out the mortality rate of peritonitis, secondary to perforative appendicitis, has dropped from 16.9% in the previous five years to 3.8% in the five years of sufonamide use.

Whenever sulfonamides are given, untoward results may occur.[11] As a rule, compared to the large number of patients taking sulfonamides, the reactions are infrequent and not of a serious nature. Serious results may occur as toxic hepatitis, dermatitis, hematuria, aplastic anemia, agranulocytosis, leukopenia and purpura; therefore injudicious use of sulfonamides is prohibited. While sulfonamides are being used, the blood level should be frequently determined for the concentration of the drug in the free and acetylated form. Febrile reactions may occur following some sulfonamides and, at times, following a readministration of any of the drugs.[12] According to some, they are more common following prolonged sulfadiazine.[13]

The local reactions which may occur after local use of sulfonamides have been discussed. They too are rather infrequent and, at most, manifest themselves in some signs of local irritations. However, general reactions may occur from the use of sulfonamides locally. Any appearance or toxic signs following the use of sulfonamides must be immediately treated energetically. The fear that following the use of sulfonamides intraperitoneally adhesions may form has not borne out. In thousands of patients on whom sulfonamides have been used, adhesions or other types of peritoneal reactions have rarely been encountered. Experimentally, however, adhesions were produced in dogs with sulfathiazole and these adhesions could be prevented by the simultaneous use of Heparin.[14] The local use of sulfathiazole causes more reaction

and reports of convulsions following its use on the brain have been reported.[15]

URINARY TRACT. The organisms of the colon group and staphylococcus group are very susceptible to sulfathiazole, sulfadiazine or sulamyd; sulfathiazole being preferable for staphylococcus. Hence, in any infections of the urinary tract, these three substances have been found very successful. Sulfadiazine or sulfathiazole in doses of 3 to 6 grams daily are used. While sulfonamides are used in urinary infections, any obstruction to the free flow of urine must be removed. Fluids should be forced and the urine should be alkalinized by the oral intake of either bicarbonate or sodium citrate. It is advisable to use sulfonamides in smaller doses prophylactically prior to instrumentation of the urinary tract and in cases with indwelling catheter.

FRACTURES: The incidence of infection in compound fractures has been reduced by the use of sulfonamides. However, the results are not always striking and, frequently, it seems that the bacterial infection is merely delayed or attenuated. In these wounds, which have fractured bones exposed, contamination is very likely to occur if they are left open; hence, it is better to close them completely especially if seen within six to eight hours. The combined local and systemic or the systemic use of sulfonamides alone have not decreased the number of local infections in this type of case, although the incidence of septicemea has been lower.

OSTEOMYELITIS. Sulfonamide therapy has been of help here especially in carrying the patient over the initial period of septicemia. However, abscesses have formed and had to be drained surgically as the necrotic, contaminated and purulent material found in these abscesses inhibits sulfonamide action.

BURNS: In burns various sulfonamide dressings have been used with encouraging results. A recommended sulfonamide dressing is 3% sulfadiazine in 8% triethanolamine applied as a spray until a thin, pliable elastic and translucent eschar results.[16] Recently, sulfonamide ointments ready for use as prepared dressings have been found of value in the treatment of burns.

SOFT PARTS WOUNDS. Extensive studies[2] have shown that, just as in cases with compound fractures, sulfonamides locally or generally do not decrease the incidence of local infection even though the morbidity and mortality has been decreased. Nevertheless for prophylaxis of wound infection, especially if proper surgical treatment must be delayed, it is advisable to locally instil sulfanilamide alone or mixed with sulfathiazole, and at the same time, give the patient sulfadiazine orally or parenterally.

GAS GANGRENE. Gas gangrene can be treated with a mixture of sulfanilamide and sulfathiazole after primary debridement and by large doses of sulfathiazole by mouth in addition to the usual measures (antitoxin). Here too, however, the sulfonamides are not very successful.

Among other surgical conditions in which the use of sulfonamides either prophylactically or therapeutically is beneficial we can mention preoperatively: thrombophlebitis, primary peritonitis, cholangitis, intra-abdominal abscesses, carbuncles, furuncles, ileitis, diverticulitis, ulcerative colitis; and post-operatively, pulmonary atalectasis and others.

According to Long[8], a combination of systemic with local therapy offers the best chance for prevention of wound infection and for its cure once it has become established. He suggests sulfadiazine orally in doses high enough to maintain a blood concentration of 4 to 7 mg. per 100 cc. as the best suitable drug for systemic administration and sulfanilamide alone for local use. Daily blood levels, blood counts and urinalysis should be done. In the absence of clinical infection, there is no reason to continue oral therapy for more than five to seven days. Occasionally, organisms become resistant to sulfonamides. This usually occurs after small doses of sulfonamides (ineffective) have been given for a long time.

In children, sulfonamides solution may be given intraperitoneally or intrasternally.

Because of the fact that sulfanilamide is inactive in areas containing necrotic purulent material, attempts were made to combine this drug with substances that act in the presence of such tissues. Recently it has been shown that a mildly oxidizing agent (azochloramide 1:3000) may potentiate the action of sulfanilamide.[17] Allantoin and urea[18] also have been suggested to combat the effect of sulfonamide inhibitor substances on necrotic tissues. The field of sulfonamide

potentiation has only recently been started to be investigated.

PENICILLIN

One of the newest and most highly promising substances in the field of chemotherapy is penicillin. The data are so new and such rapid changes have occurred in potency and mode of employment that no definite statements can be made now which will not be obsolete in a short time. It is seen, however, that this substance will complement the sulfonamides in many infections. To date, some of the reports stress the fact that certain infections in which sulfonamides have proven ineffective, the addition of penicillin has resulted in miraculous cures. Penicillin is used in the form of sodium or calcium salt.[10] It is comparatively stable but must be kept at a comparatively low temperature, now over 50° F. Penicillin is destroyed by boiling, by acids, by alkali, by certain heavy metals and by oxidizing agents. Penicillin cannot therefore be given orally unless in a form which prevents decomposition in the gastro-intestinal tract. Because it is rapidly excreted from the blood into the urine, it must be given at frequent intervals. Most of the penicillin can be recovered from the urine as the pure drug; some of it is inactivated in the body.

The mode of action of penicillin is unknown although some studies point to a bacteriostatic effect.[20] Others[21] state that penicillin actually kills organisms. Penicillin acts slowly. In the usual concentration given it does not affect leucocytes. It acts in the presence of pus, blood, serum and tissue lysates.

Penicillin is of low toxicity, and it is thought that whatever is present is due to impurities. No anemia or leucopenia has been observed. No local reactions occur from its intramuscular injection, especially when it is dissolved in normal saline. The toxic dose was found to be about sixty-four times the therapeutic dose; hence, it has a wide margin of safety.

Penicillin is most effective against gram positive organisms, and less so, or not at all, against gram negative organisms with the exception of meningococci and gonococci. It does not affect the tubercle bacilli, typhoid, dysentary of Friedlander bacilli. In vitro, anthrax and actinomycosis were found susceptible to its action.[22]

According to reports, penicillin is superior to any of the sulfonamides in the treatment of staphylococcus infections with and without bacteremia, including acute osteomyelitis, cellulitis, empyemia, infected wounds, meningitis, and carbuncles. It is quite effective in hemolytic streptococcal, pneumococcic, gonococcic infections, and anerobic streptococci. The results with sulfonamide resistant gonorrhea and pneumonia are striking. It is of questionable value in ruptured appendix, liver abscesses and urinary tract infections and also in the treatment of subacute bacterial endocarditis.

The dose of penicillin varies from 50,000 to 100,000 units or more daily depending on the type of infection. Adequate dosage has not been definitely established. It is given intravenously or intramuscularly. The solutions should be made shortly before use. For intravenous use one-half of the daily dose is dissolved in 1000 cc. normal saline or 5% dextrose. The first 100 to 200 cc. should be given rapidly, then the rate is reduced to 30 to 40 drops so patient will receive 2000 to 5000 units per hour. Intramuscularly, about 10,000 to 20,000 units are given every three to four hours.

For the treatment of infected or pleural inflammation, penicillin may be injected directly into these cavities. It has been recommended that abscesses be aspirated when possible instead of incised so that the cavity can be maintained in which to inject the drug. Penicillin can also be given through the subarachnoid space in the treatment of meningitis. For infection into empyema cavities after aspiration of pus or fluid, 30,000 to 40,000 units, depending upon the size of the cavity, may be used. Penicillin solution should not be used for irrigation since at least six to eight hours are required for a maximal effect.

The value of penicillin in surgery may become more apparent when more reports of its effect in osteomyelitis and other staphylococcus infections which have been resistant to previous therapy become more numerous. Already to date it appears that penicillin will be of great help in clearing up these resistant cases of chronic osteomyelitis and pyemia cavities and possibly actinomycosis fistulae which heretofore have been the bane of the surgeon. The results following penicillin are usually prompt and, at times, quite striking. The temperature chart is not a good criterion of the progress; better evidence is ob-

tained from the blood cultures, subsidence of pain and improvement in the general state.

TYROTHRICIN

A substance related to penicillin which has been found effective in the local treatment of infections is tyrothricin.[22,23] Isolated from Bacillus brevis this substance consists of two fractions — gramicidin and tyrocidin. Tyrothricin possesses a relatively low toxicity. However, it cannot be given subcutaneously or intravenously because it produces hemolysis. It is used in the form of a suspension containing 500 micrograms per cubic centimeter. This suspension as prepared is isotonic and entirely safe for general use locally. Herrell has reported on its use in a large series of cases with various types of lesions (ulcers, wounds, sinus disease, bone lesions, bladder and peura) and with a variety of organisms.

For the successful treatment with tyrothricin it is important that it comes into direct contact with the infecting bacteria. It kills gram-positive anaerobic bacteria with great rapidity. It is not destructive to tissues. Because it is insoluble in water, it does not penetrate tissues and hence does not produce toxic symptoms following local application. Tyrothricine is a valuable agent to supplement surgical procedures where the local use of sulfonamides have failed. Because tyrothricin must come into actual contact with the bacteria to be effective, it, like penicillin, cannot be used for irrigation but must remain for sometime in contact with the lesion. Furthermore, because of this characteristic, it seems to be more effective in acute infections where the infected organism is nearer the surface than in chronic infection. It is very successful in streptococcic ulcers. It does not affect Escherichlia coli, Proteus or Friedlander's bacillus. Because of the fact that penicillin is more soluable and penetrates the tissues, it is likely that when penicillin becomes more easily obtainable, it will supplant tyrothricin.

AZOCHLORAMID

In the last few years azochloramid[24] has been used comparatively widely in the local treatment of wounds. Azochloramid is a chlorine solution which liberates chloride at a very slow rate. This permits the dressings to remain effective for a long period of time when in contact with wounds. It is a non-irritating and effective general bacterial agent. It is usually used in saline solution 1:3300. It can be used for irrigation and can be used as moist packs and dressings. It is superior to Dakin's solution in that it does not react with organic matter. It too may become less useful when more penicillin is available.

ZINC PEROXIDE

In the past decade zinc peroxide was introduced in the treatment of many different types of surgical infection, particularly those in which the causal organism was shown to be micro-aerophlic or anaerobic as well as infections produced by the hemolytic streptococci. In general it has been found that bacteriologic studies of the wounds should be made before the zinc peroxide is used. Infections produced by anaerobic organisms respond readily to zinc peroxide. Cuts which frequently contain organisms responding to zinc peroxide, are those found in the mouth, around the vagina and rectum and those due to gunshots or to lacerations obtained in dirty areas. The use of zinc peroxide in infected wounds was started by Meleney[25] following some experiments on a series of chronic undermining ulcers. It has proven to be a valuable adjuvant in the treatment of infections due to anaerobic bacteria. Meleney suggested its use in ulcerative colitis as an enema.

SUMMARY AND CONCLUSION

Chemotherapy has proven itself a valuable adjuvant to the surgeon although it has certain limitations which must be recognized.

The sulfonamides are powerful chemotherapy agents, specific in their action on certain organisms and without effect on others. They can be used locally, enterally or parenterally. They are inhibited by pus, necrotic material and tissue juices; hence, must be used locally only after those substances are removed.

Penicillin promises to be even more effective than sulfonamides and it appears to affect more organisms than the sulfonamides. It has the advantage that it is more penetrating, non-toxic and can act even in the presence of pus and necrotic material.

Tyrothricin kills bacteria when used locally in infected cuts. It cannot be used systemically and it may be superceded by penicillin.

The other chemotherapy agents, azochloramid and zinc peroxide, are somewhat older chemotherapeutic agents which may become over-

shadowed in the near future by the greater availability of penicillin.

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SULFADIAZINE BRINGS ABOUT RECOVERY IN RARE DISEASE

A sulfanilamide derivative — sulfadiazine — brought about the recovery of a physician suffering from the rare but usually fatal pneumonic plague, Edgar J. Munter, M.D., of the U. S. Public Health Service, San Francisco, reports in the May 2 issue of *The Journal of the American Medical Association.*

"As far as I am aware," Dr. Munter says, "this case is the first to be reported in which primary pneumonic plague has been treated by the use of sulfadiazine and the patient has recovered."

The physician who suffered from this form of plague involving the lungs had been engaged in research investigations at the Plague Investigation Station of the U. S. Public Health Service in San Francisco.

In addition to the large doses of sulfadiazine, the patient was also given penicillin, but Dr. Munter says that "there was no evidence that the administration of this drug altered the course of the disease."

Pneumonic plague, caused by a germ, is an infectious disease of an extremely virulent nature, and is usually fatal. Although it is comparatively rare in the United States, several cases were reported in 1924.

GOLD THERAPY IN RHEUMATOID ARTHRITIS

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Arthritis is the most prevalent of all chronic diseases. In the United States the number of persons afflicted by it is probably over seven million. It has been estimated that nearly one hundred million man days are lost each year in this country on account of the group of diseases commonly called rheumatism. This is a greater loss of effective manpower than that caused by any other group of diseases with the exception only of mental and nervous disorders. Likewise arthritis is the oldest disease of which record can be found. Evidence of disease of the joints has been preserved in pre-historic animal remains, which have lain buried for hundreds of millions of years, and evidence of arthritis has also been demonstrated in the earliest human remains which have been unearthed.

Rheumatoid arthritis constitutes a very large percent of all cases of arthritis. This discussion deals with a method of treatment of rheumatoid arthritis and since this method is almost entirely ineffective in the treatment of any other form of arthritis, I believe it is important to dwell for a moment on the nature of the disease.

As you well know, no one has ever advanced a satisfactory theory as to the cause of this disorder. It has numerous characteristics of an infection and seems to be related to streptococcus hemolyticus, since serum agglutinins to this microorganism are often found in high titre. The evidence, however, is all indirect. The possibility of bacterial allergy and of bacterial toxins as causes, has been considered by those who have studied this form of arthritis. There are those, too, who advanced such theories as disordered metabolism, food allergy, endocrine disturbances and vitamin deficiencies, but none of these last theories has many adherants and we must await further work on the problem.

Rheumatoid arthritis characteristically develops insidiously, usually in young to middle aged persons, who have experienced some degree of ill health from infectious, metabolic, endocrine or other disorders. At the outset there is often fatigue, exhaustion, loss of weight and a

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general decline of health, all of which lead up to the characteristic joint manifestations. These early signs are accompanied by low grade fever, mild leucocytosis, anemia, tachycardia, an increase in the erythrocyte sedimentation rate, and finally by intermittent or constant pains in certain joints. As the joints become involved it is usual to find the body affected symmetrically. The joints of the extremities, especially the proximal interphalangeal joints of the hands, are frequently affected first, and there is a tendency for this involvement to progress toward the trunk. The fusiform appearance of the fingers is very typical of early rheumatoid arthritis. From these beginnings the course is toward chronicity with remissions and relapses, until in cases of long standing there may be atrophy of muscles, contractures, destruction of articular surfaces, cachexia and invalidism. On the other hand, this unhappy sequence, occasionally, and for no easily explained reason, may become arrested with or without treatment. And it is important to bear this in mind in the evaluation of this, or any other form of therapy.

By the means at our disposal some of these changes may be prevented, and some of them may even be reversed. The usual therapeutic measures, including analgesic drugs, physical therapy, vitamin therapy, in moderate or heroic amounts, vaccines, climatotherapy, and the removal of foci of infection are familiar to us all, and it is to be regretted that none of them has brought relief to more than a comparatively small percent of those afflicted by this disease. It is likely that through the efforts of those who have devoted their lives to the understanding and treatment of arthritis, better methods and better drugs will continue to be developed to combat the disease.

I think it is proper to say that the use of certain gold compounds gives the greatest hope of relieving, arresting and possibly in some instances of curing rheumatoid arthritis. Gold came into some prominence in the mid-1920's in the treatment of tuberculosis. In France and Austria certain similarities between tuberculous joint disease and rheumatoid arthritis were observed. Perhaps these observations led to its use in the latter disease. At any rate both in France and in Germany gold salts soon began to be used in the treatment of rheumatoid arthritis. These studies were quickly followed by studies in England. The initial highly favorable results were soon tempered by severe, and occasionally fatal reactions so that the enthusiasm with which the use of gold had been hailed, diminished, especially in the United States. Accordingly, it was not until the mid-1930's that clinical investigations, with improved preparations and methods, got under way in this country. Nearly all the reports of the use of gold salts appearing in the literature before 1939 came from Great Britain and Europe. In the United States the names of Boots, Cecil, Dawson, Freyberg, Hartung, Hench and Key, to mention only a very few, have been prominently associated with the study of this method of treatment in the last seven years.

It is generally recognized that the use of gold salts in rheumatoid arthritis is not without danger to the patient even under careful clinical observation and laboratory control. Without this observation and control, its use in the present state of our knowledge is definitely not to be undertaken. Many careful clinicians have withheld their approval of the use of gold because of the inherent dangers connected with its use. Tegner as late as 1939 bespoke these feelings when he stated that, "a disease of unknown etiology was being treated with a drug of unknown action but of widely known toxic properties." In the last five years, however, a very considerable amount of careful work has been done and much valuable knowledge has been gained. And I think it is proper to observe that the use of gold salts in rheumatoid arthritis is constantly and with justification gaining ground in the United States. The danger associated with the use of gold salts in this disease has its origin in two facts — first, gold salts are eliminated from the body very slowly, often over a period of many months after treatment has been discontinued, and second, there has not been found any effective method of treating the toxic reactions when they occur.

It should be emphasized that the general therapeutic measures which have gained approval through the years should always be continued in conjunction with gold salt therapy. Of these, physical and mental rest comes first if the disease is active, that is if there are fever, blood changes and acutely swollen and pain-

ful joints. Physical therapy, including heat, hydrotherapy, gentle massage and at times, short wave diathermy are helpful. Exercise is important, especially if weight bearing can be avoided, but it is best to forego any activity in the acute stage of the disease. Of the analgesic drugs, acetylsalicylic acid takes first place in doses of 0.6 gram, and 2½ grams daily are usually well tolerated. The correction of iron deficiency anemia by appropriate therapy is important. It is interesting that there are those who believe that the gold therapy itself, if small amounts are used, stimulates the blood forming organs and tends to correct the anemia. The better plan is to give iron anyway. Transfusions of whole blood serve the purpose of helping the anemia, and also they seem sometimes to have a beneficial action on the arthritis, and it is probable that transfusions as a therapeutic measure are not used often enough. It is generally believed that special diets which are unbalanced in their fundamental constituents are of no value. The use of large, even massive amounts of vitamins has not won the approval of more than a small number of students of arthritis. At present they have largely been discarded. It is important to emphasize that gold salts should be used early and in conjunction with all these measures and not reserved as a last resort, after the failure of other means of treatment. All agree that gold is much more effective in early than in late rheumatoid arthritis.

In the United States there are now three salts of gold which are used in rheumatoid arthritis, practically to the exclusion of all others. They are gold sodium thiomalate (Myochrysine), gold thioglucose (solganol-B Oleosum) and gold sodium thiosulphate. The first two contain 50% of gold, and the last 37% of gold. All are soluble salts, that is they are largely excreted in the urine. The thioglucose is supplied as an emulsion for the purpose of retarding the rate of absorption. The effects of these salts are practically identical and dosage is the same, measured, of course, according to their gold content. In addition to these three salts of gold, there has been developed a compound known as Lauron which is aurothioglycoanilide. This compound was introduced by Dr. M. J. Lewenstein of Amsterdam, Holland. It is undergoing clinical investigation in this country. Preliminary reports on this preparation have indicated a lower toxicity than in the other three commonly used salts, but perhaps also a diminished therapeutic value. It has been proved that the therapeutic effect of gold salts is due to their contents of gold, since these salts, devoid of the gold radicle, are entirely without value in this disease. There has been a tendency in the last few years, largely as the result of work by Freyberg and his associates at the University of Michigan, to give smaller doses of gold and perhaps smaller total amounts than were usual some years ago. Accordingly, doses usually begin at 5 or 7½ mg. of the metal and progress rapidly at weekly intervals to 25 or possibly in some cases to 50 mg. The total amount of gold given is usually limited to 500 or 600 mg. of the metal in any one course.

As stated before, very careful observation of the patient for signs of toxicity is exceedingly important. These may manifest themselves in their early stages by pruritis, sore mouth, loss of appetite, albuminuria, a rash, etc. The urine should be examined each week both chemically and microscopically. The erythrocyte sedimentation rate should be determined about every three weeks and the blood examined somewhat more frequently. If these are done regularly in conjunction with careful clinical examination of the patient, the earliest signs of toxicity are not likely to escape notice. The limiting of the maximum individual dose to 25 mg. of gold makes the occurrence of reactions less likely.

Physiology: The metabolism of the soluble gold salts is very imperfectly understood. The form in which they circulate in the blood has never been determined. It is known that the plasma contains practically all the gold which is in the blood. The blood cells contain practically none. The kidney is the only organ in which significant amounts of soluble gold salts are to be found. In contrast to this, the insoluble gold salts such as colloidal gold and colloidal gold sulfide are found mainly in the liver. These insoluble salts are practically inert as far as the rheumatoid arthritis is concerned and they produce damage to the liver where they are taken up by the reticuloendothelial cells. It is an interesting fact that soluble gold salts are excreted in appreciably larger amounts in the first 24 hours after injection, although this

amount may be not more than 10% of the amount injected. The conclusion drawn from this is, that while nearly all of the gold becomes bound in a less easily excreted form, some of it is thrown out by the kidney before this binding takes place. It has been demonstrated that gold is present in the synovial fluid in no greater and usually in smaller amounts than in the plasma. This indicates that the action of gold is primarily not local. Since only a small percent of the gold injected is excreted in the usual seven day interval between injections, there is a constantly increasing accumulation of the metal in the body, and the larger the individual dose is, the larger will be this accumulation. With doses of 50 mg. of the metal, gold will be found in the plasma for from six months to more than one year after discontinuation of treatment, while with doses of 12½ mg. the plasma becomes gold free in from one to three months. It has been demonstrated by Freyberg that the plasma concentration of gold does not increase appreciably when the size of the individual dose remains constant. The amount of gold retained by the body at the conclusion of a course of injections is well over 80% of the total amount injeeted in an average course.

The beneficial effects of gold salts seem to be directly related to their solubility. Some four years ago gold calcium thiomalate was developed, and it was hoped that because of its low solubility as compared especially with the sodium thiomalate and the thiosulfate, its potential toxicity would be lessened. It was found on the contrary that probably because of this lessened solubility, its action was unpredictable, its therapeutic effects, generally were lessened, and its potential toxicity was increased. The oil suspension of gold thioglucose decreases its solubility by about 1/3 and plasma concentrations are approximately ½ of those reported when the thiomalate or thiosulfate is used. It is a debatable question whether or not retardation of solubility of gold salts is a desirable feature of gold salt therapy. Gold salts, even the soluble salts, are very slowly excreted and this fact is coupled with their accumulation in the body during a course of gold therapy. The mounting accumulation of a toxic drug such as gold is cause for concern when toxic reactions occur, for it means that the reactions may extend for long periods — that is until the gold has been eliminated from the body. It is generally recognized that no salt of gold which is lacking in potential toxicity has therapeutic value in the treatment of rheumatoid arthritis. It would be very helpful if a means of gauging the dosage of gold salts could be established by blood plasma determinations of gold as can be done in the potassium thiocyanate treatment of hypertension. This has been attempted by Freyberg, but the results were disappointing. It was found that the plasma gold levels seemed to bear no very direct relationship to the frequency or the severity of toxic reactions. As the result of these investigations, the conclusion was that toxicity in gold therapy is rarely due to parenchymatous poisoning except when the kidney is involved. That this toxicity might be in some way related to allergy in a very broad use of the word, has been considered. In an attempt to substantiate this, gold as metal or as soluble salt, alone or in combination with plasma, was used in cutaneous and intracutaneous test in patients suffering from toxic reactions to gold therapy, in patients without reactions to gold therapy, and in patients not treated with gold. The results were entirely negative in identifying the nature of a possible allergic basis of toxic reactions. Therefore the hope of recognition of early toxicity by these means must await further investigations.

Toxic Reactions: It has been shown without question that the frequency and severity of toxic reactions parallel the rate of administration of the drug. That being the case, the lowest rate of administration consistent with therapeutic efficiency is desirable. Total amounts administered usually should not exceed 500 mg. of the metal in any one course and 25 mg. is probably the maximal desirable individual dose.

The most frequent toxic reactions involve the skin. They are not usually very serious. There may be only a fine desquamation of the eyelids. Pruritis alone is not usually considered sufficient cause to discontinue treatment. Most other skin manifestations such as herpes, folliculitis furunculosis, and exfoliative dermatitis call for a temporary or permanent discontinuation of treatment. Probably the most serious toxic reactions involve the blood. Of these, granulocytopenia, and thrombocytopenia, hemorrhagic manifestations and aplastic anemia are espe-

cially to be feared. These almost always necessitate permanent abandonment of gold therapy. Ulcerative lesions of the mouth and the intestinal tract, nephritis and hepatitis are relatively uncommon manifestations of gold intolerance. As stated before, it is very important that a careful examination of the patient be made before each injection for the purpose of early recognition of any of these changes.

The erythrocyte sedimentation rate is considered a helpful index of the state of the patient. It is generally believed that with a markedly increased rate, treatment should be continued, and that with a rate approaching normal, the treatment should proceed cautiously. The general condition of the patient is always to be considered in the interpretation of the sedimentation rate. Clinical improvement, in the presence of a rapid sedimentation rate is likely to be temporary. Toxic reactions seem to occur less frequently when the sedimentation rate is high.

The chance of a patient's having some sort of reaction ranges from 35 to 50 percent, but the chance of a serious reaction is very small. These various reactions are the only obstacle to more general use of gold salt therapy.

Results of treatment: It is difficult to evaluate the results of gold therapy in rheumatoid arthritis. A complete return to a normal life is the goal of all treatment. Too often it cannot be attained. Statistics by different investigators are sometimes difficult of comparison. In general, it can be said that between 60 and 70 percent of those people treated by this method will have a remission or be markedly improved. Those cases treated within the first year of the disease are more likely to experience good results. It should be emphasized that gold salts only arrest inflammatory processes in rheumatoid arthritis. They do not repair damage already done.

It is usually considered advisable to give a second course of gold within 1½ to 3 months after a first course, no matter how good the results of the first course have been. Sometimes several courses are needed. It is generally believed that the maximum improvement is to be derived from the first course. In other words, the patient is not likely to be better after the second or subsequent courses than after the first one. Relapses are the most discouraging feature of gold therapy. They occur in from 30 to 50 percent of patients who have had one course, often in from 3 to 4 months after the course has been completed. The earlier the case is treated, the less likely are relapses to occur.

The comparatively short duration of the studies of gold therapy makes it desirable to maintain a conservative attitude concerning the final evaluation of this drug. It is fair to say that no other method of treatment has even approached the use of gold in relieving the patient. Complete arrest of rheumatoid arthritis, as the result of gold treatment, occurs too seldom. Great improvement including those completely relieved and implying a return to a reasonably satisfactory state of health may be hoped for in from 60 to 70 percent of those treated. Another 15 percent are apparently helped moderately or slightly. Then there will be about 15 or 20 percent who are not helped at all.

Contraindications: In general, gold salt treatment should not be undertaken in the presence of disorders which, themselves resemble toxic reactions to gold therapy. Thus it is definitely contraindicated in most skin disorders except psoriasis, in the presence of hemorrhagic tendencies, nephritis, hepatitis, ulcerative colitis, diseases of the blood forming organs and in marked allergic states. It is contraindicated also in pregnancy and in diabetes mellitus.

CONCLUSIONS

In conclusion, I should like to point out that while the use of gold salts in the treatment of this very distressing disease is not the ideal solution of our therapeutic needs, it offers much more chance of giving lasting relief than any other method or group of methods thus far developed. We may fear the toxic reactions which are to be expected in some of these patients, and also the possibility of permanent damage to the liver, the kidneys or to other organs. But I believe that when one compares the results of gold therapy with those of any other means of treatment, he should take heart. It is axiomatic that every precaution in the prevention of toxic reactions must be taken, and this implies very careful supervision of the patient by the physician at all stages of treatment as well as afterwards. It is not an easy program for patient or physician. We may look forward, however,

to the time when still better methods will be placed at our disposal, when a better understanding of the disease and its treatment will enable us to help a greater number of these afflicted people, and with less danger to them.
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ACTIVITIES OF THE DIVISION OF MATERNAL AND CHILD HYGIENE

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The Illinois Department of Public Health, for administrative reasons, is divided into 15 divisions such as the Division of Sanitary Engineering, the Division of Vital Statistics, the Division for Venereal Disease Control, etc. It might seem that only the Division of Maternal and Child Hygiene is specifically interested in the pregnant woman and in children of all ages, but, as will be demonstrated, there is considerable overlapping with other divisions which also have programs for the same groups. Furthermore, Maternal and Child Hygiene divisional programs are not entirely limited directly to children and mothers as is easily recognized in the fields of nutrition, social hygiene, and the hospital program for the distribution of human plasma and serum.

Thus, the Division does not stand alone in the field of Maternal and Child Hygiene. It is part of the State Department team of divisions, working closely with all of them, but has the responsibility for quarterbacking the attack in the fields of maternal, infant, pre-school and school health; keeping in mind at all times that someone else may call a good play, and that the rest of the team — those who carry the ball and tackle the job — those who receive the plaudits — are in the local health departments and medical societies.

Almost all of the Division functions will fall into one of the following classifications:

1) Formulation of policies and procedures for use in Maternal and Child Hygiene programs by the local health departments and by other divisions. These are worked out with advice and suggestion from other divisions, and are not adopted until reviewed by them, but it is a special responsibility of Maternal and Child Hy-

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giene to be the clearing house for all Maternal and Child Hygiene policies. On occasions, as in the recent development of immunization policies in which Local Health Administration, Communicable Diseases, Maternal and Child Hygiene and the Division of Laboratories have overlapping interests, by mutual agreement, the Division of Communicable Diseases became the spokesman for all divisions, thereby representing the department. Only by recognizing the principle of teamwork can we avoid establishment by various divisions of different policies for the same programs.

Except for rare situations, policies and procedures serve as a guide, not a mandate, to local health departments.

2) Collection of statistical and other information and evaluation of Maternal and Child Health needs and facilities in the State, or in selected areas of the State.

3) Consultation service through the Division of Local Health Administration by specialists in the fields of Maternal and Child Hygiene, nutrition, public medical care programs, social hygiene, etc. to local health departments and other divisions.

4) Direct service by loan for a day or week or month of Division personnel to Local Health Departments, such as the service of nutritionists, or maternity hospital consultants, etc. In new programs, e.g. for Maternity and Infant Care, direct service may be administered by the Division until such time as it is practicable to move it out to the local health department.

5) Handling Children's Bureau title V allotment to the State. This involves cooperation with other divisions, such as Dentistry, Public Health Nursing, Local Health Administration, etc. all of whose needs are in part met from Children's Bureau funds.

6) Development and maintainance of relationships with State level medical, hospital, and lay groups to the end that there can be achieved, in closest harmony, optimum Maternal and Child Health benefits in this State.

To promote this objective, a medical advisory committee consisting of 10 widely known and representative physicians was appointed last July. All major divisional programs, and all new or radical changes are first discussed by this committee, and except in emergencies the division would not act without previous committee approval. Another committee, which is freely consulted and which has an active part in divisional thinking is the Maternal Welfare Committee of the State Medical Society, four members of which are on the advisory committee. Frequently, the State Council is also asked for its approval of new or changed programs before they are developed. I believe it is no exaggeration to say that there is reciprocal confidence between these groups and the State Department. All of these medical groups have interlocking personnel.

Likewise, the important matters pertaining to the hospital participation and relationships are discussed with the government relations committee of the Illinois Hospital Association.

Finally, there is a large committee consisting of physicians and other prominent citizens. This committee was appointed by Governor Green, and although it has not yet actively participated in Divisional programs, that is largely because the EMIC Program has overshadowed other activities until just recently.

Probably there should be a small committee of 5 local health officers to act in an advisory capacity to the Division in Maternal and Child Health. Up to the present time, the flow has been from Maternal and Child Hygiene out, that is, what there has been, and such a committee might advantageously channel ideas from local health department to Maternal and Child Hygiene.

It is thus obvious that the Division of Maternal and Child Hygiene is a correlating and coordinating agency.

Different committees do not always arrive at the same conclusions. We have had that experience. It is then necessary to bring them together, and, as a general rule, a decision satisfactory to all concerned can be worked out. If not, it is probably more effective in the long run and wiser, to allow time for reconsideration than to thrust ahead; wiser, not because one fears opposition or criticism but because a plan which can be actively supported by all interested groups is almost bound to be sound and certainly has a good chance of success. You can count on something worth while coming out of a meeting of minds, even though it may be somewhat delayed, and not what you originally anticipated.

We have taken time to describe these basic principles of divsional policy because there has been no such statement in recent years, and understanding is a prerequisite against which to silhouette the following outline of present and planned divisional work. It is difficult if not impossible to classify such work under mutually exclusive headings. For example, the premature centers could be discussed under infant hygiene, hospital programs, or medical care programs. Therefore, no attempt is made in this paper to set up classifications. May I emphasize that each of the following subjects is only briefly outlined in this paper — each could easily use a full period in itself.

The Maternal Program. Statistics reveal that the maternal mortality rates for the State have shown progressive improvement over a period of many years. Nevertheless, the rates in Chicago are considerably below those for the rest of the State and it behooves us to emphasize methods to reduce the rates still further, especially downstate. The following programs will assist in reducing maternal morbidity and mortality.

1) The Maternity Hospital Law in January 1940 placed the responsibility for licensing, inspection and regulation of maternity hospitals, lying-in homes, or other places, public or private, for the confinement of women, in the State Department of Public Health. Since that time, all maternity hospitals have been visited, some frequently, by specially trained hospital consultant nurses and obstetricians from the Division, and, on the basis of their recommendations, a great many improvements have been made in nursing techniques and hospital plan arrangement and equipment. The nurses act as teachers and spend several days in a hospital demonstrating approved nursing techniques for the nursery, the formula room, and the care of post partum patients. As is to be expected, there has been some interruption because of the war in the plans of many hospitals to make building changes and equipment additions.

Each hospital renders a monthly statistical report, which is carefully studied and tabulated by the Division. These monthly reports are combined into an annual report. That for 1943 was recently completed and each hospital received its own report, as well as average figures for hospitals of similar size, and for all hospitals in the State. This report can and should serve as the basis for study by each hospital staff. For example, the hospital with the highest mortality rate (about 6 times that for the State as a whole) also had the highest Caesarean rate (about 3½ x that for the State as a whole). This does not necessarily mean there is a relationship but it does indicate the need for study by the hospital staff. Likewise, the transfusion rate in hospitals under 50 beds was too low to tabulate and as hospitals of greater size are tabulated a straight line upward graph results. This is worthy of study, and many other leads can also be obtained from these reports.

2) Prenatal clinics — There are only a few in the State, and they serve two purposes — first, to give service to a needy group or to a group in areas where other medical service is inadequate, and second, to focus public and medical attention on the value of adequate prenatal and other maternal care. The percent of patients receiving care in such clinics in Illinois is very small. I am not aware of any studies which are sufficiently conclusive to be the basis for determining the number and distribution of clinics which Illinois needs. There is a belief in some quarters that more clinic facilities are urgently needed for the negro populations of some downstate areas. This is being studied.

3) Prenatal classes for expectant mothers (and fathers) — Physicians everywhere, including Illinois, have been very slow in demanding this educational service from their local health departments. Those health officers in Illinois who have attempted to interest physicians in such classes for private patients have had almost no success. This is a matter with which each health officer, or county maternal welfare chairman, or other interested physician, should become thoroughly acquainted, and should place in the laps of the local societies for consideration. There are reports in the literature which indicate a noticeable reduction in morbidity and mortality among mothers attending such classes, and a purely educational effort such as this, is something that every doctor could support. Success depends on the interest of the physician. He can make or break such classes merely by the opinion he expresses to his patients.

4) Public Health Nursing visits to maternity

eases in the prenatal and postnatal period.

A physician who has never had the assistance of a competent nurse or technician in his office gets along quite well, not realizing what he is missing. In the same way, perhaps 90-95% of physicians in Illinois are "getting along" without the benefit of visits by public health nurses to their maternity patients, and yet, in most of Illinois, doctors and their patients could have this service which is in every way advantageous to the doctor if his relationship and the relationship of his society with the local health department are sound. In ten Illinois counties, such visits are common and physicians have actively objected to removal of this service. In effect, it provides the doctor with his own home nursing service, supervised by him, working under his direction, and reporting back to him.

Health officers and public health nurses should be aware of the two objections usually raised by physicians, 1) that the nurse shows favoritism towards certain physicians, and (2) that she may not use only those standing orders which have been approved by the local physicians. These objections are usually based on misunderstanding and can be ameliorated.

5) *Review of maternal deaths by hospital staff* — In 1943, 87.6% of all Illinois deliveries were in hospitals. There were 295 maternal deaths, (provisional) Every death should be critically reviewed by the hospital staff, or by its committee. The mere study of such deaths can be expected to result in lower morbidity and mortality rates. Many Illinois hospitals now do this, and it should be a priority program with every county society and hospital.

6) *Refresher courses in obstetrics and pediatrics* — An effort will be made through the teaching staffs in the Chicago area to provide another series of these courses. They may be shortened to one week as a war measure, and might well be attended especially by physicians in counties which have had unexplained high morbidity and mortality rates in recent years. Perhaps there will be an opportunity this year to include an hour or two round table discussions on the use of public health nursing, home delivery nursing service which is important in a few counties, prenatal classes, and the importance of study by physicians locally of all maternal and infant deaths.

7) The State Department of Public Health of Illinois has sponsored a hospital program for the collection of blood, processing and distributing it to hospitals as serum or plasma at almost no cost to the hospital or patient. The plan has been endorsed by the medical advisory committee and by the council and is expected to receive approval of the Hospital Committee at an early meeting. It is high on Dr. Cross's priority programs at this time and will be actively promoted from now on.

These then are some major programs at this time designed to reduce the hazards to maternity in Illinois. Others are contemplated but not yet formulated.

The Infant Hygiene Program. — What has been said about maternal hygiene in many instances also applies to Infant Hygiene. In addition, there is a program for breast milk, and another for premature care, that deserve description.

The Breast Milk program — At the last general session of the Illinois legislature, $20.000 was appropriated with which to provide breast milk for infants who need it and cannot obtain it from its normal source. The policies for this program have been formulated in detail and we are now awaiting the delivery of priority equipment. As far as I can determine, no other State has attempted a statewide program of this kind and some pioneering will have to be done. It is estimated that about 150,000 cc. of milk from outside sources would be needed in downstate Illinois. This progam will be started on a modest scale, perhaps in July, but as planned, is capable of expansion if funds become available, if donors can be obtained, and if doctors wish to use breast milk. As now organized, it will be a local health department function, with the milk the property of the State.

Illinois now has two premature centers in operation — one in Peoria, and the other in Springfield. Perhaps 40% of infant deaths are complicated by if not attributable to prematurity. Many of these infant deaths may be prevented by the proper use of heat, breast milk, oxygen, and the prevention of infection. The plan provides for hospitalization in specially equipped and prepared hospital premature centers without cost to the family on the recommendation of the physician. Nurses in attend-

ance at the premature stations are given special training at State expense, and a consultant pediatrician is retained at a monthly honorarium to consult with attending physicians or to furnish care if the attending physician so desires.

It is proposed to institute another center in Moline in the near future. Centers cover as much territory as is safe for transportation of the premature.

It may be that the future will see the development of feeder hospitals to these highly specialized centers, somewhat as has already happened in the field of x-ray therapy. Premature care is an expensive service if given on a small scale.

The Pre-school Group. — This, the neglected age group from a public health program point of view, and difficult to work with because of its diffusion and lack of organization, has not received special study by the Division recently. Even those pre-school age activities of long standing have suffered, and sometimes collapsed in these war years. Nevertheless, this group has important problems and deserves much better understanding and planning than it now receives.

School Hygiene. — The past year witnessed what may be the most important development in school health in Illinois in all its history. Through the efforts of the Directors of three State Departments, Public Health, Public Instruction, and Registration and Education, under the direction of Claire Turner and statewide committees, there has been developed a joint statement of school health policies. You will learn much about this in the near future. Suffice it today to say that the Division of Maternal and Child Hygiene will formulate its school hygiene program in accordance with the joint report which will be released soon.

Nutrition — For several years, the Division has employed four full time nutritionists who have spent one or two months at a time as members of a local health department. Except for Cook County, no local health department now has a full time nutritionist. Beginning in September, two counties will have nutritionists assigned to them for 4 months each, and another two counties will have the same service the second half of the school year. At the same time, service for a month or so each in several counties will be continued. Two or more nutritionists will be added to the budget for the next fiscal year and it is hoped that before long a few of the larger county health departments will have full time year round service by a nutritionist permanently attached to the local health department.

The division service is closely coordinated with the work of the statewide committee on nutrition which represents all active groups.

Medical Social Service — The Will County Health Department and the Peoria Health Department are the only two Illinois health departments so far as I know which have medical social service workers. The Division now has a medical social service consultant. Her job is to assist in the development of policies which may help local health departments and private physicians to bridge the gap which now prevents use by patients of services available from health and welfare agencies. This promises to be a development of major significance, and progress will be reported at a later date.

Emergency Maternity and Infant Care. — This is a wartime public medical care program which will have served at least 21,000 patients in Illinois by July 1, 1944. Approximately $2,000,000 will have been authorized and the fact that it has been such a big program explains the temporary lack of emphasis in other Maternal and Child Health developments this last year. This program in Illinois has been reported in greater detail elsewhere.

Social Hygiene. — A very small beginning was made this year towards the development of this program at the local level. Three health officers expressed an interest in sending representatives to a short demonstration and workshop which the Division will conduct later this month. This program is not to be confused with Venereal Disease control. It is essentially a teen age activity of an educational nature designed to assist girls and boys to make desirable adjustments to meet the transition from adolescense to early maturity.

SUMMARY

A general statement is given concerning the methods used by the Division in maternal and child hygiene programs.

Present activities are discussed briefly and fields of future emphasis are indicated.

Physical Medicine Abstracts

John S. Coulter, M.D.

THE FUNCTION OF THE PATELLA AND THE EFFECTS OF ITS EXCISION

Herbert Haxton, B.Sc., Ch.M., F.R.C.S.,
Oxford, England
In SURGERY, GYNECOLOGY AND OBSTETRICS, 80;4;395
April, 1945

1. The patella is a sesamoid bone developed in and lying in the line of the extensor tendon of the knee.

2. Its phylogenetic and ontogenetic development indicate it probably has a function.

3. Experimental work shows that the patella improves the efficiency of knee extension in the more important extended positions of the knee joint by holding the patellar tendon away from the axis and thereby increasing the extending moment of the quadriceps pull.

4. Clinical investigations confirm the experimental findings.

5. Patellectomy is justifiable in patellofemoral osteoarthritis.

ACTIVE MOTION BY MEANS OF OCCUPATIONAL THERAPY IN THE TREATMENT OF FRACTURES

Lester Breidenbach, M.D., and Elizabeth Jamison, O.T.,
New York, N. Y.
In SURGERY, GYNECOLOGY AND OBSTETRICS, 80;4;365
April, 1945

1. Occupational functional therapy is a distinct help in the treatment of injuries to the extremities. It rehabilitates the patient in the shortest possible time.

2. By means of the arthrometer and proper charting, progress becomes an accurate measurement rather than a guess.

3. Treatment is continuous and is carried out at the occupational clinic and at home.

4. Return to normal function is shortened in fractures of the extremities.

5. An accurate chart of all joint ranges is appended.

CALCIFICATION OF THE TENDON CUFF OF THE SHOULDER

M. Beckett Howorth, M.D., Sc.D. (Med.), F.A.C.S.,
New York, N. Y.
In SURGERY, GYNECOLOGY AND OBSTETRICS, 80;4;343
April, 1945

Pain and spasm may be relieved in some cases, especially the acute ones of short duration, by any one of several treatments.

Heat, in the form of a lamp, hot water bag, electric pad, or hot packs, may provide some relief. Short or long wave diathermy may relieve some shoulders, and may even be followed by absorption of the calcareous material in the early acute ones. However, an acute shoulder, with inflammation of the bursa, or tension in the tendon, is often made worse by heat.

Cold is usually more comforting than heat, especially in the very acute cases. Ice packs may be used, but the ethyl chloride spray, as reported by Kraus, is usually more effective.

Massage of the bursal region is likely to increase the pain in most cases, though gentle massage of the adjacent muscles may be used to maintain muscle tone. Manipulation or stretching usually increases pain and spasm, and often does more harm than good.

Exercises are of great value, and are the most important of the various physical therapeutic measures.

The pendulum exercises are the simplest,

easiest, and least painful; they should be done with the arm in flexion and hanging loosely, i.e., with the trunk flexed, or with the subject lying prone upon a table with the arm over the side.

Aspiration, irrigation, or puncture of the calcified area may give relief, chiefly by the release of tension.

A QUICK AND SIMPLE TREATMENT OF LOW BACK PAIN BASED ON A NEW CONCEPTION OF ITS GENESIS

Aladar Farkas, M.D., and George W. Easley, M.D., Williamson, W. Va.

In THE WEST VIRGINIA MEDICAL JOURNAL, 41;4;107
April, 1945

The routine of the treatment in more than 60 cases was as follows: After the clinical and x-ray examination the patients were placed in beds whose front legs were raised 12 to 20 inches. Beneath the mattress a board was placed. The patients retained a small cushion for their heads if necessary and were kept in bed day and night. Daily for twenty minutes a heat cradle was applied. The duration of the treatment varied from seven to fourteen days, but in no case exceeded a fortnight.

The pathogenesis of the low back complex (lumbago, sciatica, protruded disc) is explained on the ground of a primary lumbar kyphosis, a straight lumbar spine preceding all signs and symptoms. The reverse of lumbar lordosis is caused by stooping and sitting occupations. Among the signs accompanying the disappearance of lumbar lordosis attention is called to the spasm of the lateral abdominal muscles and to the lumbar shift of the dorsal kyphosis. In more than 60 cases complete relief from the local and nervous symptoms could be obtained by putting the patient in a bed, the front legs of which were elevated from 12 to 20 inches for from seven to fourteen days. Recurrences were rare and easily handled by the same method.

CANCEL PHYSICAL MEDICINE MEETING

The annual scientific and clinical session for 1945 of the American Congress of Physical Medicine has been cancelled. This meeting was to have been held in New York City, September 5 to 8, 1945.

OSTEOARTHRITIS OF THE SPINE

Ernest Fletcher, M.A., M.D., M.R.C.P.
Physician, Queen Mary's Hospital, Stratford, London; Physician, British Red Cross Society's Clinic for Rheumatism, London;
Physician (with Physical Medicine) Royal Free Hospital, London;
Physician in Charge, Medical Division, E.M.S.

In THE BRITISH JOURNAL OF PHYSICAL MEDICINE AND INDUSTRIAL HYGIENE, 8;2;51
March-April, 1945

The diagnosis of osteoarthritis of the spine is made fairly frequently, but it is not by any means the commonest of the medical locomotor disorders. In 1,500 carefully recorded cases of chronic rheumatism it occurred 84 times, 37 times in males and 47 times in females. This compares with 377 cases of infective arthritis in the same series, which also included 90 cases of ankylosing spondylitis. The average age at the time of onset was 55 years. The average duration of symptoms at the time of diagnosis was 23.6 months.

Anatomical evidence has been produced to show that osteophytic formation occurs in the short intervertebral ligaments and that this lesion has a certain incidence in the spine. Osteoarthritis of the apophyseal joints and its incidence is also discussed.

Clinical evidence is adduced which suggests that polyspondylitis does produce symptoms, although some workers maintain that it does not (Gordon). The symptoms of osteoarthritis of the spine are described, together with the physical signs. An attempt is made to correlate the clinical and anatomical findings. The radiographical view-point is considered and its difficulties are mentioned.

No attempt is made to assess treatment, but it is quite possible that separation of the two main forms of osteoarthritis of the spine may lead to modifications in treatment.

TREATMENT OF FRACTURES OF THE TIBIAL CONDYLES

Robert A. Knight, M.D., Memphis, Tennessee

In SOUTHERN MEDICAL JOURNAL, 38;4;254
April, 1945

Postoperative Care and Results. — Early protected motion without weight bearing has been found to be the most satisfactory method of restoring function. Immediate postoperative immobilization consists of a long leg cast with a

pelvic band with the knee in 15 degrees of flexion. In two or three weeks, after the wound has healed, the cast is removed and the extremity is suspended in balanced traction for active and passive motion. Daily physical therapy is given, the patient being instructed in quadriceps exercises, and care is taken to prevent forcible flexion of the knee. At the end of five to six weeks, the patient is allowed up without weight bearing, wearing a long leg control dial knee brace.

REFRIGERATION ANESTHESIA IN SURGICAL PROCEDURES

Damon B. Pfeiffer, M.D., and F. M. Simmons Patterson, M.D., Abington, Pa.

In THE PENNSYLVANIA MEDICAL JOURNAL, 48;4;352

January, 1945

The use of reduced temperatures has long been known, but it was not until about twelve years ago that refrigeration was used for anesthesia. Dr. Frederick M. Allen has been an outstanding pioneer in advocating refrigeration in various procedures. As a result of experimental work that he performed in an effort to find improved means of handling cases of diabetic gangrene, we have learned the advantages and limitations of refrigeration anesthesia. Its principle is best explained in his own words: "Basically, refrigeration anesthesia reduces metabolism to a point which is just compatible with tissue viability. Thus, in a leg with advanced arteriosclerosis, metabolism can be reduced to a level where the existing circulation is adequate for the needs of the tissues . . . Nerve impulses are abolished. Also, one of the fundamental properties of protoplasm, which is irritability, is arrested by cold. Therefore, this method differs fundamentally from all previously known anesthetics in producing anesthesia not only of nerves but of protoplasm . . . Under refrigeration, shock is nonexistent, and the duration and degree of tissue trauma immaterial.

SUMMARY

1. Refrigeration is the chilling, not the freezing, of tissues.

2. Refrigeration anesthesia is indicated in aged, poor-risk diabetics with gangrene of an extremity that requires amputation. Nine limb amputations under ice in diabetics are reported with one death.

3. In Individuals with gangrene of an extremity due to arteriosclerosis or peripheral vascular disease, and who are bad risks, refrigeration is the anesthetic of choice. Three successful cases are reported.

4. The technic of limb amputations under ice is described, and the advantages of this procedure are listed.

5. Refrigeration anesthesia is often a life-saving procedure when gangrene, infection, toxicity, and possibly septicemia exist. The patient may be thus improved to the point where conservative or radical surgery is rendered possible.

6. Refrigeration of badly crushed extremities retards shock and bacterial growth and permits the patient to be improved generally by transfusions, etc. Amputation with no further anesthetic agent may then be safely performed.

7. Refrigeration offers many advantages in the treatment of burns.

8. In fresh embolism and thrombosis, refrigeration of the limb extends the limits for successful embolectomy. It also gives marked symptomatic relief, and makes possible later radical surgery. Two successful cases are reported.

9. Severe cases of frost-bite often respond miraculously to the application of cold.

10. The value of refrigeration has been extended to the field of skin grafting.

11. Sixteen cases of limb amputations were performed under ice with only one death. All patients were exceedingly poor risks.

Industrial Health

Committee On Industrial Health — Frederick W. Slobe, Chm., 2024 South Western Ave., Chicago, Frank P. Hammond, H. A. Vonachen, R. I. Barickman, C. O. Sappington, Milton H. Kronenberg.

CAUSALGIA

Just as it occurred in the last war, causalgia is a rather frequent manifestation following injuries in the present war and, no doubt, will become increasingly more frequent in the future as the casualties increase in number and as more time elapses.

The following article by Captain Francis D. Threadgill illustrates some interesting features of the diagnosis:

RESIDUALS OF WAR WOUNDS OF THE EXTREMITIES*

Captain Francis D. Threadgill
Medical Corps, Army of the United States

Causalgia, an annoying and frequently disabling sequela of wounds near nerve pathways, is being encountered more and more often in wounds sustained during the fighting in Italy. This phenomenon is a delayed complication, coming after such wounds have fully healed, and is well known to all war surgeons. It was first described by S. Weir Mitchell,[1] and his paper has remained a classic since the Civil War. It is apparent that its usual appearance some time after the original injury accounts for the cases coming to attention at this time in this theater, where fighting has now been going on for approximately seven months.

Wounds near the larger nerves, with no immediate evidence of injury to the nerve, are those in which this vaguely understood condition may develop. The patients do not experience sensory disturbance until some weeks after injury and almost invariably not until healing of the wound has occurred. Causalgia may affect any area of the body, but the usual areas involved are the arms, forearms and leg, owing to the fact that wounds involving them are seldom fatal and that great nerves and vessels in these areas are more subject to injury than elsewhere.

Burning pain of an extremity with aching of muscles and loss of epicritic sensation over the course of one or more peripheral nerves are the characteristics of the disease early in its course. Loss of the sensation of light touch is its most prominent diagnostic feature, as it is very definite; whereas in the hysterical patient and the malingerer sensation is usually greatly amplified or completely absent. This one sign has been found of great value, and its presence will almost certainly assure a satisfactory response to block of the sympathetic nerve supply of the area.

This paper will deal only with cases of patients in whom the condition is in an early stage and who have shown no vascular, gross muscular or osseous changes. The statements and opinions made are drawn from a study of such cases. It is in such cases that treatment is satisfactory, for later in the course of the disease irreparable changes develop, varying from trophic cutaneous changes to extensive absorption of bone. Sensation in the advanced stage is usually hypercritical, causing the patient to go to such extremes as to wrap the involved part in urine-soaked rags, as wet applications are found to decrease pain. Classic cases of this type are described by Mitchell.

Examination of these patients reveals, depending on the duration and severity of the process, some atrophy of the affected extremity and usually the cutaneous changes of disuse. No impairment of motor function is present. The sensory changes are characteristic and diagnostic of the disease. One finds paresthesia exactly over the peripheral distribution of one or more nerves, with loss of sensation to light touch. Pressure sensation is not lost, and the response to heat and cold is usually exaggerated. Muscular ache involves the great flexors and extensors of the member and is not well localized. All symptoms are increased with use of the part, and the patient's chief complaint is his fear of using the extremity because of his knowledge that his symptoms will be greatly increased.

It is understandable that a man wounded in combat may wish to defer his return to the front. The myriad complaints that develop during the stay of such soldiers in the hospital make the medical officer prone to turn a deaf ear all too easily to one whose wound has no ap-

*WAR MEDICINE — Vol. 6 No. 5 Nov. 1944. Quoted in part only, not including case reports and summary which are shown in the original article.

1. Mitchell, S. W., cited by Davis, L.: The Principles of Neurological Surgery, ed. 2, Philadelphia, Lea & Febiger, 1942.

parent possibility of producing nerve damage. The patients I have seen have all been returned to duty after an uneventful recovery of their primary wounds. All of them stated that their "causalgic" symptoms did not appear till days or weeks after the primary injury.

The difficulty of diagnosis is great, as malingering and the neuroses are easy to confuse with causalgia. It is important, however, that the entities be separated, for treatment of causalgia is both simple and generally satisfactory and permanent disability may be avoided if therapy is exhibited shortly after or while the process is developing. Recently, Spurling and Scoville[2] have shown that herniated cervical intervertebral discs produce a type of pain that may be confused with causalgia. The constant involvement of the neck, however, should serve to rule out this condition, together with such other conditions as cervical rib, or scalene, syndrome.

The pathologic process responsible for this condition is an imbalance of association of the central and autonomic nerve supply. That such is the case may be suspected on consideration that the description of the disease is that of an essential atavism. Anatomically, one may postulate that a lesion has interrupted the nerve pathways of the autonomic system about vessels to and from the part, causing a dyssynergism with loss of correlation of the two normal channels of sensation. It is probable that one is dealing here with an overactive autonomic supply from the affected area, which has lost modifying fibers injured by trauma higher up and some distance away from the nerve itself. It is known[3] that peripheral nerves carry both cerebrospinal and autonomic tracks; with fibers entering all along the course of the nerves, loss of parts of integrating autonomic factors will explain the process, much as motion is regulated by the cerebellum. Following a block of the sympathetic nerve supply of the area the complete relief of pain secured gives an insight into the picture, as apparently loss of the sympathetic return of the part allows the central nervous system alone to assume and integrate normal sensation.

The immediate relief of pain secured in causalgia by the simple procedure of block of the lumbar or cervicodorsal portion of the sympathetic trunk is gratifying to all concerned. It is a truly dramatic proof of diagnosis in a field fraught with hysterical conversion and malingering among patients seldom seen by the neurologist until irreversible changes have occurred.

It is probable that some patients with causalgia will recover spontaneously, and it is obvious that some with definite nerve injury may show causalgic symptoms in addition to more positive evidence of damage. Of the patients whose cases were studied, one who became clinically worse after the procedure was later shown to be a definite psychopath. Another man entering the hospital with severe pain and aching of the arm and forearm was completely relieved after two injections. The third, who showed no response to the procedure, has been found to have definite ulnar damage and is to have neurolysis.

2. Spurling, R. G., and Scoville, W. B.: Lateral Rupture of the Cervical Intervertebral Discs, Surg., Gynec. & Obst. 78:350-358 (April) 1944.

3. Ranson, S. W.: The Anatomy of the Nervous System, ed. 5, Philadelphia, W. B. Saunders Company, 1935.

TRAUMATIC SURGERY AND NEURO-PSYCHIATRY

In "War Medicine" for October, 1944, some interesting abstracts appeared from which the following selections have been chosen:

A Physiologic Analysis of the Nature and of the Treatment of Burns. W. W. L. Glenn, Ann. Surg. 119:801 (June) 1944.

According to Glenn, the local treatment of burns necessitates the consideration of three fundamental lesions: injury to the epithelium; injury to the vascular bed, particularly the capillaries in the burned area, and injury to the surrounding and supporting tissues. It is believed that the underlying cause of the lack of uniformity in the treatment of burns has been failure to appreciate this triad of lesions and the physiologic changes brought about by them.

After discussing these lesions, the author reviews the therapeutic requirements of burns, enumerating them as follows: a protective noninjurious covering, control of capillary leakage and immobilizatoin of the part.

The following are the requirements of the protective covering: 1. The dressing must do no further damage to the burned surface. 2. The covering must afford protection from contamination. 3. The protective covering should require infrequent change.

In connection with the control of capillary leakage, the author evaluates pressure dressings and nondistensible dressings and then stresses the importance of immobilization. Finally he dicusses the clinical use of closed plaster dressings. There is no harm from this treatment. There were no instances of injured circulation. The prompt return of function of a part immobilized in plaster over prolonged periods has been one of the most gratifying features of this treatment. Not the least important is the comfort obtained by this treatment. The plaster dressing is easy to apply to burns of the extremity. The slight degree of after-care of the burned area is one of the chief advantages. Pain or discomfort in an encased extremity occurring twenty-four to thirty-six hours after application of the dressing was relieved by elevation of the part.

The following directions are given for using closed plaster dressings in the treatment of burns: after minimal cleaning and débridement and without breaking blisters, two layers of sterile gauze are laid over the burned surface extending above the area to be covered by plaster. If fingers are involved they are enclosed separately in the gauze. A thin sheet of rolled plaster bandage is then applied to the part without pressure, extending over the end of the extremity and 2 to 4 inches (5 to 10 cm.) above the burn. In mild burns the

encasement is removed in seven to fourteen days. In more severe burns it may be left in place for as long as four weeks. If the burn is incompletely healed or the epithelium is unusually thin, another encasement should be immediately reapplied. Grafting may be started as soon as the slough separates.

Numbness beneath the plaster is an indication for prompt removal. No cases of this have yet been observed, and with correct application none should develop.

Infection beneath the encasement is usually well localized and as a rule does not warrant removal of the encasement. Sulfonamide compounds on the burned surface are of questionable value.

Use of a Saturated Iodoform-Benzoin Solution to Counteract the Odor of Plaster-Encased War Wounds. C. M. Silver and H. W. Rusbridge, Mil. Surgeon 95:233 (Sept.) 1944.

Silver and Rusbridge recommend the use of a saturated iodoform-compound tincture of benzoin solution to counteract the foul smell encountered in plaster-encased war wounds.

At a station hospital functioning overseas a saturated solution of iodoform in compound tincture of benzoin was painted daily over the discolored, malodorous portion of the cast. The resulting odor is relatively agreeable, and the solution is absorbed readily by the plaster surface.

The authors have employed the iodoform-tincture of benzoin solution in more than 100 cases of compound war wounds during periods ranging up to seven weeks without change of the original plaster of Paris casing.

"Ring" Sequestra as a Complication of Fixed Skeletal Traction. C. P. Truog, Am. J. Roentgenol. 52:64 (July) 1944.

Truog points out that a complication which occurs not uncommonly with skeletal traction is the formation of "ring" sequestra. The author has observed 7 instances of such sequestra at an orthopedic clinic in the past two years. Six of the patients had been treated for fracture with pins incorporated in plaster casts which extended from the toes to above the knees with about 15 degrees flexion at the knees. The patients then became ambulatory and were seen in the outpatient clinic. Five of these 6 had pins inserted through the upper tibial fragment and the calcaneus. One had a pin driven through the distal fragment as well as the proximal fragment. These 6 all had delayed union. The seventh patient was treated with the Kirschner wire extension. He had had a fracture of the femur and humerus as well as of the tibia and fibula. Nonunion occurred in both the femur and the tibia, necessitating bone grafts.

The author gives detailed reports of the 7 cases. He stresses that roentgenologists should give special attention to such cases, as the diagnosis of ring sequestrum will depend entirely on the roentgen examination. It is important to make the diagnosis as soon as possible, so that the skeletal traction may be removed.

Constant traction under these conditions may lead to extensive damage to bones or to migration of the pin out of the bone into soft tissues, epiphyses or joints.

The cause is probably pressure necrosis plus a low grade infection.

Bone-Drilling in Delayed Union of Fractures. M. E. Pusitz and E. V. Davis, J. Bone & Joint Surg. 26:560 (July) 1944.

Pusitz and Davis do not offer a new method of bone-drilling in delayed nonunion but emphasize a worth while procedure that is often neglected in the treatment of fractures.

This report is concerned with the cases of 25 consecutive patients treated at a military hospital.

Bone drilling is not a method of choice in the treatment of definite nonunion. Rather, it is intended for the treatment of delayed union. It is, of course, difficult to differentiate between delayed union and nonunion. It involves not only a question of time but also a question of the roentgenographic observations. A delayed union may be still present at the end of ten months, whereas nonunion may be present at the end of ten weeks.

There are three essential types of nonunion, namely, (1) typical pseudarthrosis with sclerosis of the ends of the fragments, (2) fibrous union with osteoporosis of the fragments, and (3) fibrous union with atrophy of disuse.

In delayed union, although there may be no discernible callus, there is no sclerosis of the ends of the fragments. If there is absolutely no evidence of callus formation at the end of four to six months, delayed union may be considered to be present.

A large number, probably the majority, of delayed unions will ultimately unite if immobilization is adequate and continued long enough according to the functional method of immobilization of Böhler. However, this may take eight months or eighteen months, and certainly a proportion of these delayed unions will resolve themselves into nonunions. If a method is available which is simple, carries with it little potential danger and yet gives a large percentage of success, it should be practiced.

Delayed union is the primary indication for bone drilling. It should be performed within a four to six month period.

Open operation should be practiced. The incision should be as short as is consistent with complete exposure of the fracture. The dissection should be minimal, in order not to interfere with the local circulation. The stripping of the periosteum from the bone should also be minimal, for similar reasons. A series of thirty to fifty holes are then drilled in the following manner: Starting above the fracture site, a dozen or more drill holes are made across the line of fracture, but diverge as they cross the fracture site. In a similar way, drill holes are made with the point of convergence below the fracture site.

After the bone has been properly drilled, simple closure is effected. The part is then properly im-

mobilized, as after a fresh fracture, and with as much care. A well fitting, non-padded plaster of Paris cast is applied, to which a walking caliper is added after a week or ten days. The functional method of treatment, as described by Böhler, can then be adopted with profitable result. In the upper extremity, the cast or Roger-Anderson fixation may be used.

The authors also discuss subcutaneous bone drilling and then review 25 consecutive cases in which bone drilling was done.

In all cases except one there was bony union, both clinically and roentgenographically. The average time required for the development of union after drilling was eight weeks. The shortest period was three weeks (after fracture of a clavicle), and the longest was five months. The patients were up and around in a walking cast a week or ten days after operation. There were no postoperative infections.

Psychiatry in the British Army. J. R. Rees, Am. J. Psychiat. 101:20 (July) 1944.

In war not only does the group matter more than the individual, but the lesser and more preventable diseases are vastly more important than the clinically more interesting but much rarer disorders. Psychosis is much less frequent and much less important from the point of view of winning the war than neurosis and the associated problems of lowered morale. In consequence, much emphasis has been laid on what might be called social psychiatry and especially on the preventive mechanisms, of which selection is chief.

Selection, founded on a thorough analysis of all the jobs to be done in the Army and matching of men to those jobs on a basis of their quality, intelligence and specific aptitudes, has been an undoubted success. Not only has far greater efficiency resulted, but training has been better, sickness and delinquency have been reduced and morale has benefited.

In this war there is practically no one who is not fully employed either in the services or in industry, and consequently the utilization of man power is a vital matter. The Army has been unable to reject all inferior and inadequate human material and to keep only that which is best. Both backward and neurotic men have to be used wherever possible, and in consequence much thought and effort have been given to devising the best methods of management of these particular groups. One example may be given — that of the very dull men, with a mental age from 8 to 10, whom it is difficult to employ in any full combatant status. The worst soldiers turn out to be the best laborers when properly grouped together under good officers and noncommissioned officers who understand them. Neurotic men who have a long history of emotional and psychosomatic difficulties do good work when they are wisely placed with regard to occupation.

The results of the treatment of true battle neurosis, when it has arisen in the line, have been satisfactory. Between 30 and 50 per cent of men with such neuroses are got back to combatant duty with their units in four or five days. Sedation after abreaction with good rest for a day or two are sufficient to deal with many of these men, and few of them need to leave the combat area, since even though not immediately fit to go back into the line they can be employed in other tasks.

Current Trends in Military Neuropsychiatry. M. J. Farrell and J. W. Appel, Am. J. Psychiat. 101:12 (July) 1944.

Farrell and Appel point out that one of the important lessons learned in the last war was that a considerable number of men who fulfilled the physical requirements for service were nevertheless noneffective as soldiers because of mental abnormalities. Men with psychoses, mental defects, severe psychoneuroses and psychopathic states were untrainable, untreatable, disturbing to morale and eventual expensive liabilities to the government. There developed what might be called "the era of diagnosis and disposal" in military neuropsychiatry. It was widely believed that psychiatric disorders did not develop in normal men, only in weaklings or in men with underlying emotional instability which could have been detected in advance.

The myth that only weaklings acquire psychiatric disturbances was exploded completely. It was found that in one campaign the incidence of psychiatric disturbances was higher among veteran combat troops than among fresh, green troops. Fatigue and other factors produced more psychoneuroses in this group than among fresh, untried troops. It became evident that any one could acquire a psychoneurosis under certain circumstances. The limitations of screening became obvious. If screening were to weed out any person who might develop a psychiatric disorder, it would be necessary to weed out every one.

Psychiatric screening can weed out only abnormal men. It cannot decrease the rate at which "normal" men break down. It runs the risk of eliminating men who, although having some defect of personality, nevertheless if properly handled can render valuable service in the Army.

The assumption that any man acquiring a psychiatric disorder was a weakling led to the policy of discharging anybody who was labeled with a psychiatric diagnosis. The wastage inherent in this policy became evident when it was demonstrated that if psychiatric disorders were regarded as medical emergencies and properly treated 60 to 80 per cent of the patients whose breakdowns occurred in combat recovered and returned successfully to full combat duty. Another unfavorable result of the policy soon became evident. Although true malingering was rare, the escape mechanism was prominent frequently close to the conscious level. The policy of discharging such men not only made the escape mechanism effective but encouraged its use. It constituted a reward for failure.

It became clear that in this war psychiatrists were going to have to do more than concern themselves with diagnosis and disposal. It was necessary to find out what was causing men to break down and then to attempt to eliminate those causes.

The rate of battle injuries is presumed to be an

index of intensity of combat, and it is shown to have a relationship with the rate of neuropsychiatric casualties. Furthermore, the percentage of neuropsychiatric casualties rises in direct proportion to the length of active combat duty.

This point is amplified by reports from psychiatrists emphasizing the role of exhaustion. Difficulty in sleeping under shell fire, in open foxholes and exposed to extremes of temperature, wet and mud, cold food and constant demands for physical exertion produce a state of physical and mental fatigue which is of paramount importance in precipitating these psychiatric breaks. Rest, induced by sedation, appears to be the most important factor in their recovery.

A number of factors were important in causing psychiatric disorders. Personality structure was merely one of several. Fatigue, leadership, morale, discipline, job assignment, motivation, training, domestic difficulties — each of these might be as important as personality structure in any given case and in combination frequently more so.

Preventive measures have been taken by psychiastrists along three general lines: (1) educational, (2) motivational and (3) environmental.

A course of six lectures on mental health is given to all officers in the Army. These cover the principles of personal adjustment, personality structure, motivation, specific stress factors, signs and symptoms of breakdowns and measures to maintain mental health of the group. A similar course of three lectures is also given to all enlisted men. These cover the following subjects: personal adjustment problems, fear, resentment, bodily effect of emotions and a healthy viewpoint toward being in the service.

To attack the problem of motivation of military personnel, the Army set up an organization now known as the Morale Services Division. It has the mission of assisting the command in supplying troops with current news and information concerning the background and causes of the war.

The majority of the factors which determine the mental health of military personnel are functions of command. In other words, the main job of preventive psychiatry must be done by commanding officers of the line. The psychiatrist acts as adviser to the command. Collaborating with the personnel classification officer, he seeks to prevent many psychiatric disorders by bringing a medical viewpoint to bear in job assignment problems.

In respect to treatment, it is the present policy to regard every patient as salvageable until proved otherwise. A second policy is that every breakdown shall be regarded as a medical emergency. It is vital to start treatment immediately, while the disorder is still in the amorphous state, in order to prevent symptoms from becoming fixed. A third important principle is to attempt to keep psychiatric patients out of hospitals, since it is well recognized that hospitalization has the effect of exaggerating the concept of illness in the patient's mind.

It is generally recognized that the concept of physical health covers a wide range of conditions; mental health, on the other hand, has been regarded as being black or white. Either a man is insane or he is completely normal. The possibility has not been considered that there might be anything in between. Actually, of course, mental health, just as physical health, ranges all the way from bad to good. A man may have minor temporary mental ill health, just as he may have a head cold. Mental disorders may be acute or chronic, severe or mild.

Many laymen become frightened and resentful when a psychiatrist applies a medical term to conditions they were used to recognizing as a "case of the jitters" or "gone stale" or "nervousness." It is difficult for laymen to realize that when a "case of the jitters" is sufficiently serious to incapacitate a man or produce insomnia and indigestion a psychiatrist may call it psychoneurosis and yet not mean anything more serious than was meant by the layman who called it "the jitters."

IMPORTANT

Send changes of address to 30 N. Michigan Ave., Chicago 2, Illinois, enclosing label from a copy showing your old address. Changes received after the 1st of the month will not go into effect until the following month.

An equitable labor policy must be established for those found to be tuberculous if the control program for this disease is to have permanent success. It has been found that health committees of labor unions are sympathetic to this type of health activity if they are informed of the full implications of the presence of a communicable disease in a fellow worker. A sick worker is a liability to himself, his family and his union, not to mention the industry and the community. When these facts are presented in their true light, rarely has there been difficulty in obtaining full cooperation. Herman E. Hilleboe, M.D. and D.M. Gould, M.D., J.A.M.A., May, 1944.

News of the State

PERSONALS · COMING EVENTS · MARRIAGES · DEATHS

★ WAR SERVICE ACTIVITIES ★

ADAMS COUNTY

Lt. Comdr. Kent W. Barber, Quincy, is now located in the Naval Hospital at Memphis, Tennessee. He is in the Department of Surgery where he was assigned following his dismissal from the hospital at Oakland, California. He was confined in the hospital for a number of months, due to a severe injury to the sole of one of his feet. While not entirely recovered, Comdr. Barber is able to take care of a part of his surgical duties.

Lt. Comdr. Walter M. Whitaker, Quincy, is located in the Naval Hospital in the Marianas, in the South Pacific. He is in charge of the Medical Department.

Major Walter Stevenson, Jr., Quincy, is now located in Rheims, France, where he is doing Plastic Surgery in a General Hospital.

Capt. Harry Ryan, Quincy, is now in California, where he is convalescing from a serious tropical skin infection. Prior to his return to the United States, he was located in the South Pacific.

Major Frank T. Brenner, Jr., Quincy, is located in the occupied area of Germany and is in a hospital in the Surgical Division.

Major Rae Hoover, Quincy, is now located in the United States, where he is stationed in a hospital at Ft. Knox, Kentucky, in charge of the Division of Urology.

Col. John Davis, Quincy, is still in charge of a hospital ship which evacuates wounded from the European Theatre of Operations to the United States.

Lt. Col. Ray Mercer, Quincy, is located in Georgia in charge of a large prison camp hospital.

Dr. George Borden, formerly of Mendon, Illinois, is now a Captain and located in England. The last we heard from him, he was in charge of the whole blood bank for that area in which he was located.

CHAMPAIGN COUNTY

The Surgeon General has announced the promotion of James Eldon Blades of Sidney from Major to Lieutenant Colonel.

COOK COUNTY

Lt. Col. Ralph H. Fouser who has been commanding officer of the Camp Ellis hospital and chief of surgical service has been named commanding officer of the Camp Grant station hospital while the post begins to prepare for the processing of European veterans headed for the Pacific war zones.

Lt. Col. Robert D. Bickel, surgeon general liaison officer at the American Medical Association offices, has been presented with the legion of merit for "exceptionally meritorious service" as commanding officer of hospitals in India and in China. The presentation was made by Major General David McCoach, Jr. commanding general of the 6th service command.

Captain Patrick Parisi, formerly of Chicago Heights, was recently awarded the Bronze Star in Germany. The citation was in recognition of efficient surgical service for the 740th Tank Batallion.

Major Sylvan W. Simon, formerly of Chicago and now with the Air Service Command in Italy, was recently awarded the Bronze Star after he led his medical detachment in stamping out a civilian smallpox epidemic before it reached the thousands of combat airmen of the 15th Air Force who were on duty at nearby airfields. Dr. Simon graduated from Rush Medical College, Chicago, in 1926 and entered the service in October 1940.

The office of the Surgeon General announces the following promotions — from Lt. Col. to Colonel. Eugene Rhea Chapman, Chicago and from Major to Lt. Col., Felix Jansey of Riverside, Morton Joseph Mills, Arthur Karl Peterson, George William Stuppy, all of Chicago.

Lieut. Martin A. Dolan after having spent considerable time in the South Pacific has been on leave in Chicago with reassignment to Great Lakes Naval Training Station.

Major Clifford Sullivan recently spent a few days in Chicago from his assignment in Tucson, Arizona.

M. O. Bousfield, M.C., has been promoted from Lieut. Colonel to Colonel. Col. Bousfield is Commanding Officer Station Hospital No. 1, Fort Huachuca, Arizona.

Irving Blumenthal, M.C., has been promoted from First Lieutenant to Captain. Captain Blumenthal is in charge of a battalion aid station on Saipan.

Among the medical men with the Michael Reese Unit which accompanied American Soldiers on their invasion of Italy were Major Alfred E. Jones, Captain Alfred J. Platt and Captain Arthur H. Schoenwetter.

Captain William Saphir on a South Pacific Island recently finished a study on the tropical disease, filariasis, which will be published soon with the approval of the War Department.

P. M. Garramone, M.C., has been promoted from First Lieutenant to Captain. Captain Garramone is stationed at the Station Hospital, Savanna Ordnance Depot, Proving Ground, Illinois.

Captain Rex D. Hammond, son of Dr. Frank P. Hammond of Chicago, has been attached to the 76th Medical Battalion, forward echelon, of the United States Third Army, under General George S. Patton, during its entire operation from the time of landing on Normandy to the end of the European hostilities in the center of Germany. In addition to battle stars, Captain Hammond has recently been awarded the Bronze Star Medal, with a citation: "This medal is awarded to anyone especially distinguished for meritorious achievement in the Army or Navy in connection with military operations against an enemy of the United States." He has recently been assigned the task of medical administrator of the famous Buchenwald prison camp, which is still crowded with refugees, slave labor nationals and convalescent atrocity victims, where, he says, "the work is extremely interesting but the prevailing conditions are appalling."

DE KALB COUNTY

Major Bernard F. Howland, a former Sycamore surgeon, entered the army 27 months ago and has been serving overseas since February 1944. He was commanding officer of a surgical unit of General Patton's Third Army in Germany. On April 20 his unit was ambushed by Germans near the Czechoslovakian border and he was wounded in the left arm and captured. During the 18 days of imprisonment he received no medical attention and very little food. In a recent letter he states that infection set in in the wounded arm, but thanks to modern surgery applied after his liberation he is recovering and expects to be back soon to take up his practice in Sycamore.

The famed 27th Infanty Division's Public Relations Office has announced the promotion of Major John F. Eggers, from his former rank of Captain.

Major John F. Eggers is the commanding officer of the medical battalion Clearing Station of the famed 27th Infantry Division, commanded by Major General Geo. W. Griner. His unit moved in support of this Division's assault on the Southern portion of Okinawa. They have availed front line troops of speedy and expert medical attention. Affording the fighting man the best treatment known to Army medical science, the battalion's motto is: "Bring 'Em Back Alive."

Major John F. Eggers previous to landing on Okinawa, participated in the bitter fighting for Eniwetok and Saipan Islands. He then served as the Battalion Surgeon in the Knickerbocker Infantry Regiment. For meritorious service during the action on Saipan, he was awarded the honored Bronze Star Medal.

His orders to report for active service, from an Army reserve commission, came from the 6th Corps Area, Chicago, Illinois, in March 1941. He served for some time at Fort McClellan, Alabama, before coming overseas in March 1942.

Prior to his Army days, Major Eggers practiced surgery and medicine in Sycamore, Illinois for 2½ years. He was associated with the Sycamore Municipal Hospital and St. Mary's Hospital of De Kalb, Illinois. He is a graduate of Northwestern University.

HENRY COUNTY

Speedy evacuation of battle-wounded soldiers to the 52nd General Hospital in England and their physical and mental reconditioning has been directed by Major Peter J. Doering, a practicing physician of Geneseo before entering

the army in September, 1942. He was appointed rehabilitation coordinator for the 12th hospital center in addition to his duties as executive officer of the general hospital.

LAKE COUNTY

Lt. Cmdr. Lawrence C. Day, formerly of Grayslake, is the senior medical officer aboard a ship in the Pacific after spending 23 months in the Atlantic. He entered the service early in 1940 and was attached to the USS Kilauea, prior to Pearl Harbor. He wears the European-African-Middle Eastern, American and Asiatic-Pacific Area ribbons.

LAWRENCE COUNTY

Major Malcolm C. Todd of Lawrenceville and Miss Ruth Schlake of Chicago were recently married in St. Margaret's Church, Westminster, London. They met while both were working at the 297th general hospital in England which is an affiliated unit of County Hospital in Chicago. Guests at the church included Lt. Col. Chester C. Guy of Chicago, the hospital's chief of surgical service and Major Hampar Kelikian of Chicago, chief of Orthopedics.

MC LEAN COUNTY

Sydney S. Schochet, Captain M.C., of Bloomington was recently awarded the Purple Heart and one Oak Leaf Cluster.

PEORIA COUNTY

Carl E. Sibilsky of Peoria, serving with the largest U. S. Army general hospital in the European Theater of Operations for the last 18 months, has been promoted from captain to the rank of major. His unit is now operating in the Paris area.

Lt. W. B. Werner, Pekin physician who has been in the Pacific area for the past 16 months as a navy flight surgeon, has just arrived in the United States.

Charles Digges Branch of Peoria has been promoted to the rank of Lt. Commander.

Henry Sargent Howard of Peoria has just received a commission in the Navy and reported to a station in San Francisco.

SANGAMON COUNTY

Promotion of Captain William J. Morginson of Springfield to Major has been announced by Col. Robert M. Hardaway, commanding officer of Bushnell General Hospital, Brigham City, Utah, where Major Morginson is stationed. He is chief of the dermatology subsection and venereal control officer at the hospital.

VERMILION COUNTY

Washburn's Island near Camp Edwards, Mass., where thousands of troops trained for the beachhead landings they later made in Africa, Europe and the Southwest Pacific, is now being used for the treatment and recreation of combat veterans who are patients at the convalescent hospital there.

Col. Holland Williamson, Medical Corps, Commanding Officer of the Convalescent Hospital, announced the new utilization of Washburn's Island today. Dr. Williamson was a practicing physician in Danville.

He asserted it would be used primarily for therapeutic treatment of convalescent soldiers. It will also be the scene of fishing, boating, swimming and other recreational programs.

WINNEBAGO COUNTY

Major John S. Bralliar, formerly of Rockford, Ill., and now commanding officer and chief surgeon of a portable surgical hospital in the Philippines, was recently awarded the Bronze Star "for meritorious service on Luzon." Dr. Bralliar graduated from the University of Tennessee College of Medicine, Memphis, in 1939 and entered the service Dec. 4, 1940.

GENERAL

ADAMS COUNTY

J. E. Miller of Quincy has been seriously ill and is still confined in St. Mary's Hospital.

Walter Davidson of Liberty and Hugh M. Tarpley and Walter Stevenson of Quincy have been appointed as members of the new County Health Board.

COOK COUNTY

Max Thorek addressed the joint meeting of the Knoxville County Medical Society and the Tennessee division of the United States Chapter of the International College of Surgeons, June 8th at Knoxville, Tennessee, on "Surgical Plagiarism, its Etiology, Manifestations and Cure."

Plans are in progress for a $750,000 addition to Ravenswood Hospital, 1917 West Wilson Avenue, Chicago. The addition will provide space for between 85 and 100 beds bringing the institution's total capacity to 250 beds. It will permit expansion of laboratories, X-ray rooms and physiotherapy facilities.

A meeting of the Western section of the Medical Group Practice Council was held at the Palmer House, Chicago, June 6-7, with Dr. Samuel Bradbury, Philadelphia, as chairman. At the luncheon meeting on June 7 Dr. Kingsley Roberts of the Medical Administration Service,

New York, presided. Drs. Morris Fishbein and Victor Johnson of the American Medical Association were guests, and Clarence Rufus Rorem, Ph.D., director of the Hospital Plan Commission of the American Hospital Association, also attended. This council is organized under the auspices of the Medical Administration Service, Inc., to promote the extension and improvement of medical group practice by preparing and disseminating publications regarding the standards, procedures, problems and values of this method of distributing medical care.

HENRY COUNTY

Worling Young of Geneseo was recently elected president of Henry County Medical Society. W. R. Smith of Kewanee was named vice-president and P. J. McDermott also of Kewanee was re-elected Secretary.

IROQUOIS COUNTY

George W. Ross was installed as mayor of Watseka on May 14.

JACKSON COUNTY

Charles E. Riseling was given a dinner May 2 in honor of his fifty-two years' service to Murphysboro and of forty-eight years' service as a member of the staff of St. Andrew's Hospital, of which he became one of the original members when it was founded in 1897.

MC LEAN COUNTY

On June 1, Edwin Marrell Minnick of Danvers, completed fifty years in the practice of medicine in Illinois. He was awarded the fifty year button and certificate of the Illinois State Medical Society at the June 12th meeting of McLean County Medical Society.

WILLIAMSON COUNTY

W. I. Lewis of Herrin was recently elected President of the Williamson County Health Council.

MARRIAGES

Howard Carrington, Onarga, to Miss Lucy Jane Hooker of Lebanon, Mo., in Camp Anza, Calif., recently.

Julian Peter Krakowski, Waterloo, to Miss Fern Zinser of El Paso, April 14.

John T. Sullivan, Jr. to Dr. Tullia D. TeSauro, both of Chicago, May 30.

Guy Parry Youmans, Chicago, to Miss Anne Louise Stewart of Springfield, Mo., in Winnetka, March 17.

DEATHS

Arthur J. Behrendt, Chicago; University of Illinois College of Physicians and Surgeons, 1891. Served on the staffs of St. Elizabeth and Grant Hospitals and Municipal Tuberculosis Sanitarium, and was surgeon of the U. S. Steel Corp. north branch for 48 years. Died in Evanston Hospital, June 10th at the age of 79.

Harry Franklin Bennett, Litchfield; Bennett College of Eclectic Medicine and Surgery, 1895. Served as Captain in World War I. Died from a cerebral hemorrhage May 18, aged 73.

Nathan Leander Bourne, Decatur; Barnes Medical College, St. Louis, Mo., 1903. Had specialized as otolaryngologist in Decatur for 41 years. Died May 17 at the age of 71.

Oscar Caraker, Olmsted; St. Louis College of Physicians and Surgeons, St. Louis, Mo., 1908. Had practiced medicine in Olmsted for 37 years. Died following a heart attack in the Cairo Hospital May 22, aged 65.

Rufus G. Collins, Chicago; Northwestern University Medical School, 1885. Had practiced medicine in Chicago since graduation. Died in Michael Reese Hospital June 24th, aged 86.

Herschell V. Donovan, Cerro Gordo; St. Louis College of Physicians and Surgeons, 1895. Died June 3rd, at the age of 73.

Samuel Beck Herdman, Taylorville; Rush Medical College, 1909. Was major in World War I. Had been chief surgeon for the Peabody Coal Company in the Midland Field since 1932. Past president of the Christian County Medical Society. Died May 18th at the age of 63 years.

James Paul Johnston, East Moline; University of Illinois College of Medicine, 1922. Served in World War I as a member of the student army training corps at Iowa University where he was enrolled in the school of medicine. Narrowly escaped death in an automobile accident on February 24th. Died of cerebral thrombosis in Hines Hospital June 10th at the age of 51.

Leon K. Leigh, Chicago; National Medical University, Chicago, 1898. Practicing physician in Chicago's loop for 47 years. Died June 13th, aged 75.

Carl Frederick Lewis, Jerseyville; Bennett College of Eclectic Medicine and Surgery, 1909. Had practiced medicine in Jerseyville for 25 years. Was stricken with a heart attack and moved to St. Mary's Hospital, St. Louis. Died May 31st at the age of 61.

James Claude McLallen, Cicero; Jenner Medical College, Chicago, 1909. Had practiced medicine in Cicero for 34 years. Died June 14th at the age of 68.

James Donal O'Connor, Peoria; St. Louis University School of Medicine, 1930; commissioned a captain in the Army Medical Corps Aug. 31, 1942; as-

sistant chief of medical service at the Air Force Base Hospital at Eglin Field, Fla. Died in Coral Gables, Fla., Feb. 24th, aged 39.

THEODORE HERBERT PAGE, retired, Peoria; Rush Medical College, 1897. Died June 11th, aged 70 in Tucson, Arizona where he had been the past 8 months.

BEN PARMENTER, retired, Keensburg; Barnes Medical College, St. Louis, Mo., 1909. Died May 10th, at the age of 64.

PETER H. POPPENS, Princeton; Rush Medical College, 1920. Died of injuries suffered in an automobile accident June 8th at the age of 55.

WILLIAM F. SCHAARE, River Forest; College of Medicine and Surgery, Chicago, 1902. Former commander of Columbia camp 2, United Spanish War Veterans, department surgeon for Illinois, and national president of the 7th Army Corps Veterans' association. Died June 19th at the age of 69.

KENNETH M. SEARS, formerly Elburn physician, major in the Army Medical Corps; Rush Medical College, 1931. Entered service in January, 1942 going to Camp Grant. Went overseas with his unit in Sept., 1944, became ill at the front and was returned to this country January 20th. Died, from an ailment incurred overseas June 2nd, at the age of 41.

BENJAMIN FRANKLIN STEELY, Louisville; Hospital College of Medicine, Louisville, Ky., 1907. Had practiced medicine in Clay county for nearly 38 years. Died in St. Anthony's Hospital, Effingham, May 18th, aged 64.

ALBERT T. SUMMERS, Mattoon; Kentucky School of Medicine, Louisville, 1903. Died in Washington, D. C. Hospital June 2nd at the age of 68.

JAMES J. TOALSON, East Alton; St. Louis College of Physicians and Surgeons, St. Louis, Mo., 1897. Formerly practiced medicine at Peoria. Died after a long illness on May 31st at the age of 72.

THEODORE H. TRAPPE, New Athens; St. Louis College of Physicians and Surgeons, 1910. Member of the Belleville Branch of the St. Clair County Medical Society. Died June 13th at the age of 67.

GEORGE W. WALBRIGHT, Metropolis; St. Louis University School of Medicine, 1930. Practiced medicine in Danville for 7 years, then entered the service as captain in 1941 serving as ship surgeon in the Hawaiian, Canton and Fiji Islands. Was discharged in 1943. Died suddenly May 24th at the age of 37.

WILLIAM K. WEST, Hinsdale; Wayne University College of Medicine, Michigan, 1889. Until 1928 he was chief surgeon for the Copper Range Mining in Upper Michigan. Died June 16th at the age of 79.

SURVEY SHOWS INTEREST IN INDUSTRIAL MEDICAL PRACTICE GROWING

About one-fourth or 4,215 of the medical officers answering a recent questionnaire indicated that they wished to enter the field of industrial medicine when they returned to postwar civilian practice, Lieut. Col. Harold C. Lueth, Medical Corps, Army of the United States, reports in the May 12 issue of *The Journal of the American Medical Association.* The questionnaire was prepared by the Committee on Postwar Medical Service of the American Medical Association to determine the future desires of medical officers. It was distributed to each medical officer on active duty with the Army, Navy, Public Health Service and Veterans Administration.

Of the 4,215 doctors who were interested in industrial practice of medicine, there were 863 who wanted full time positions and 3,352 who wanted part time positions. There were 484, or 56 per cent, who wanted special training in the field, and 379, or 44 per cent, who did not want special training. The greatest number of requests for special training came from the youngest graduates.

Interest in the practice of industrial medicine has been constantly growing among the medical profession and for purposes of future planning, Colonel Lueth points out, it is desirable to have an estimate of the likely status of industrial health in the future. An analysis of the figures shows that about four times as many men wanted part time positions in industrial medicine as wanted full time positions. Special courses in industrial health were requested by a total of 1,809 medical officers. They included men who desired full time positions in industrial medicine, men who desired part time positions in industrial medicine and men who were undecided about future positions in industrial medicine.

Tuberculosis is an infectious contagious disease. Fundamentally its control depends upon the control of the tuberculous patient who may spread the disease to those about him. For that purpose it is vital to know who has tuberculosis and to employ means to find the unknown cases in the community. The first step in finding new cases is to examine those individuals with whom the known tuberculosis patient was closely associated, especially in the home. The next is the examination of individuals who complain of symptoms referrable to the lungs. Even under ideal conditions, where these two steps are carried out with maximum efficiency, there still remain in the community large numbers of unknown cases of tuberculosis. These hidden cases for the most part have no characteristic symptoms or signs and, in the vast majority, only an X-ray of the lungs will disclose the disease. Recent advances in X-ray equipment and techniques, especially the so-called miniature film method, have made possible the X-raying of large groups of individuals for the purpose of finding these undiscovered cases of tuberculosis. William Siegal, M.D., "Health News," Nov. 13, 1944.

25731

P. R. N.

The Jocular Jingles of C. G. F.

by

Charles G. Farnum M. D.
Peoria, Ill.

INDIAN NAMES

I've driven through our Northern States,
Past towns and lakes and rivers,
With names so unpronounceable,
My voice still quakes and quivers.

Indian names! Indian names!
I found them everywhere.
I should have worn a blanket
And feathers in my hair.

Wausaukee,
Pewaukee,
Bemidji and Milwaukee;
Ypsilanti, Escanaba.
Namakana, Waukenaba.

Monona,
Wautona,
Sheboygan, Kobetcona;
Onekama, Keosauqua,
Potawatomi, Minocqua.

Zumbrota,
Wissota,
Petoskey, Minneota;
Pokegama, Kakabeka,
Wantawagang and Sebeka.

Wadena,
Wawina,
Gogebic, Kishutena;
Waukesha, Onotonagon,
Weyenwega, Namakagon.

Itasca,
Kalkaska,
Saskatchewan and Chaska;
Ishpeming and Winnebago,
Okobogi, Maukwonago.

Kasota,
Dakota,
Kenosha and Eyota;
Capac, Mohawk and Cokato,
Kawishiwi and Mankato.

Kawnipi,
Mississippi,
Waupun, Kitchitikippi;
Seneca and Oscaloosa,
Maquoketa and Nekoosa.

Minni Wonka,
Minnetonka,
Petoskey and Tetonka;
Oskenonton, Chippewa,
Winneconne, Ottawa.

Saganaga,
Onandaga,
Negaunee and Menahga;
Sheboygan, Tomah, Neenah,
Muskegon, Okebena.

Manitowoc,
Oconomowoc,
Waupaca, Oshkosh, Tomahawk;
Minneiske, Saginaw,
Calumet and Manawa.

Sakatak,
Pontiac,
Caribou, Dowagiac;
Nipigon and Algonac,
Minnewaska, Mackinac.

Manistee,
Winnapea,
Saugatuck, Menomonie;
Mishawaka, Shakopee,
Wauwatosa, Cherokee.

Home in Peoria, Illinois again,
I visit Chillicothe and Kankakee,
Watseka and Mendota,
Kewanee and Sciota,
The valley of the Kickapoo for me!

I'm very sure that no one wholly blames
My horror at these northern Indian names.

THE RED HEADS

Efficiency,
Of the highest degree,
Has the nurse whose hair is red.
Most sparklingly
Brilliant, is she,
A halo about her head.

It may be the shade of burnished gold
Or the color of carrot puree;
It may be ravishing Titian hue
Or streaked just a bit with gray.

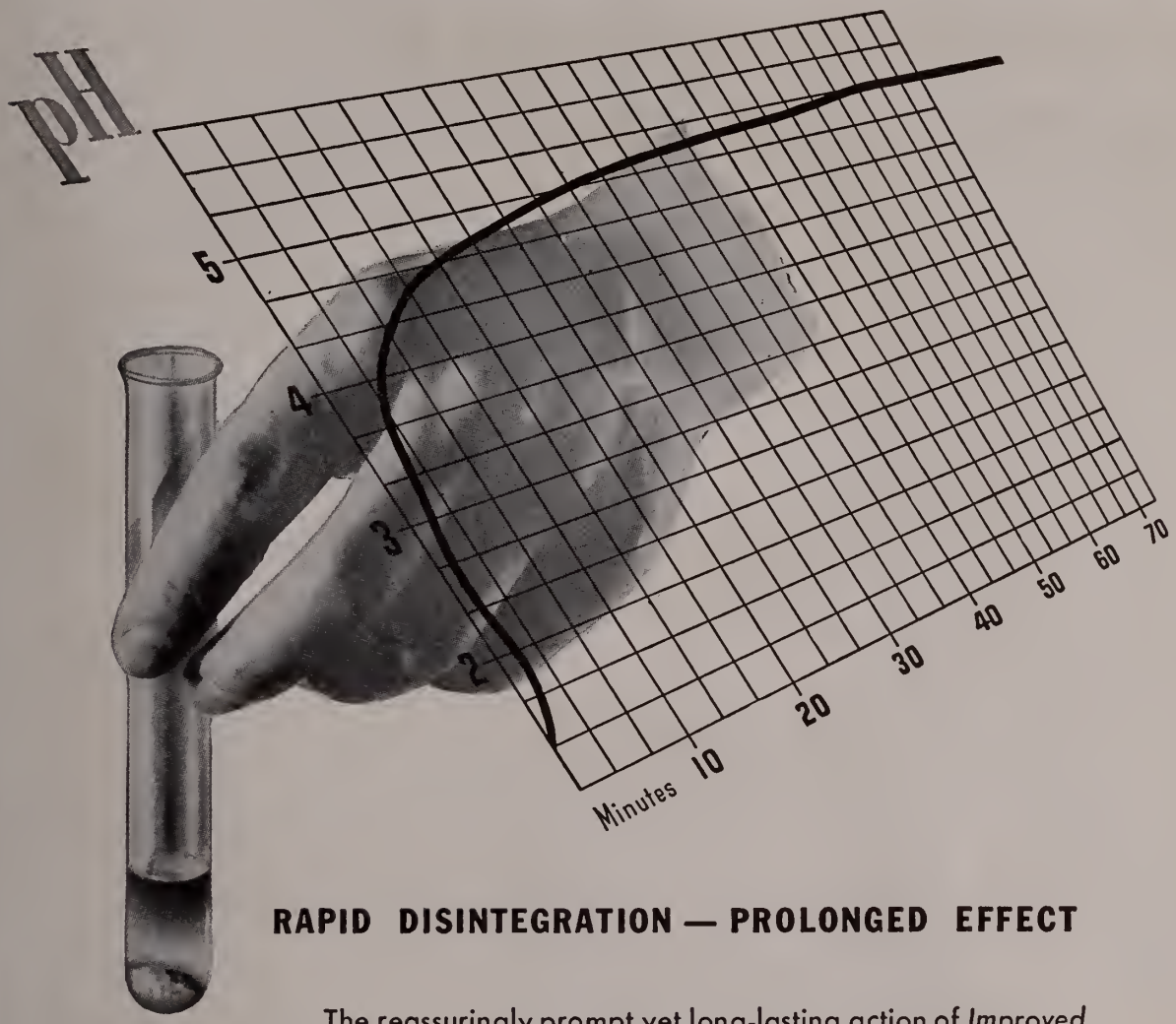
I don't care whether it's kinky or straight
Or gayly sparkles with brilliantine,
The russet red of an autumn leaf,
Or of sunlight, vespertine.

It may be auburn, sorrel or brick,
Or resemble an angora cat.
It may be golden as noon day sun,
Surmounting skinny or fat.

So when I'm sick,
And things won't click,
And I'm chucked in a hospital bed,
I will never object
To the nurse they select,
So long as her hair is red.

Professor Paresis asserts that a really considerate neighbor is one who can play a saxaphone and doesn't.

22131



RAPID DISINTEGRATION — PROLONGED EFFECT

The reassuringly prompt yet long-lasting action of *Improved* Syntrogel makes this Roche antacid the medication of choice for the modern treatment of hyperacidity. Through prolonged adsorption and neutralization of excess acid, *Improved* Syntrogel maintains the pH of the stomach close to the neutral point without inducing an undesirable secondary acid rise. Another outstanding feature of *Improved* Syntrogel is its exceptionally rapid disintegration resulting in unusually prompt relief of pain and distress due to hyperacidity and spasticity. Available in bottles of 48 and 96 tablets HOFFMANN-LA ROCHE, INC., Roche Park, Nutley 10, N. J.

IMPROVED **SYNTROGEL** 'ROCHE'

Control Summer Diarrhea

WITHOUT CONSTIPATING EFFECT...

with...



DOSAGE:

At Onset: Teaspoonful every hour until normal evacuation with proper stool consistency is restored.

Follow with: Teaspoonful before meals and at bedtime, reduce as indicated.

ZymenoL provides a twofold natural approach to the two basic problems of Common Diarrhea;

NORMAL INTESTINAL CONTENT REESTABLISHED
. . . through BREWERS YEAST ENZYMATIC ACTION*

NORMAL INTESTINAL MOTILITY RESTORED
. . . with COMPLETE NATURAL VITAMIN B COMPLEX*

This twofold natural therapy assures normal bowel function without constipating astringents and absorptives, artificial bulkage or catharsis.

Write For FREE Clinical Size

*ZymenoL contains Pure Aqueous Brewers Yeast (no live cells)



Certainly not if there is inadequate carbohydrate digestion—with distension, heartburn, intestinal fermentation and faulty nutrition.

TAKA-COMBEX provides:

1. Vitamin B complex and vitamin C—vitamins whose absorption may be impaired by digestive disturbances.
2. Taka-Diastase—a potent starch digestant that promotes more satisfactory digestion and assimilation of carbohydrates.

Prescribed for middle-aged and elderly patients, Taka-Combex Kapseals are helpful for the prevention or relief of vitamin B complex and vitamin C deficiencies, particularly when these patients need assistance in digesting starchy foods.

Each Kapseal contains: Taka-Diastase 2½ grains; Vitamin C, 30 mg.; Vitamin B_1, 3 mg.; Vitamin B_2 (G), 3 mg.; Vitamin B_6, 0.5 mg.; Pantothenic Acid (as the sodium salt), 3 mg.; Nicotinamide, 10 mg.; with other components of the Vitamin B Complex from liver.

TAKA-COMBEX KAPSEALS

BOTTLES OF 100 AND 1000

Parke, Davis & Company DETROIT 32, MICH.



Bedford Springs, Pa. (circa 1850)

AS REFRESHING AS EVER

Since Bedford Springs were discovered in 1804, thousands of patients have visited this world-famous Spa. Today, your patients can enjoy, at home, one feature which attracts many to Spas all over the world—a sparkling saline laxative.

Analyses of the waters of many Spas indicate that sodium sulfate, sodium chloride, and sodium bicarbonate are often the most important ingredients. These same salts are scientifically combined with sodium phosphate, lithium carbonate, and tartaric acid in pleasant-tasting SAL HEPATICA—providing a gentle, effective method of cleansing the intestinal tract.

For a gentle, more efficient laxative, or thorough cathartic—direct your patients to dissolve SAL HEPATICA *in a large glass (8 oz.) of water. Laxative Dose: 1 to 2 level tsps. Cathartic Dose: 4 level tsps.*

A Product of Bristol-Myers Company, 19 RR West 50th Street, New York 20, N. Y.

TO HELP FLUSH THE INTESTINAL TRACT

Sal Hepatica 

SUPPLIES Liquid Bulk!



habits can be good

Vitamin D supplementation is a good habit
and should not be broken when summer comes,
for such interruption "often breaks down habit
on the part of mother as well as child and
makes resumption difficult or impossible."[1]
Regardless of season, continue

SUPER D* CONCENTRATE

a defatted, well tolerated, drop-dosage
concentrate of fish liver vitamins A and D,
with vitamin D exclusively from cod
livers, in 5 cc., 10 cc., and 30 cc. bottles.

*Trademark, Reg. U. S. Pat. Off.

[1]The Vitamins, Chicago, A. M. A., 1939, p. 524.

FINE PHARMACEUTICALS
SINCE 1886





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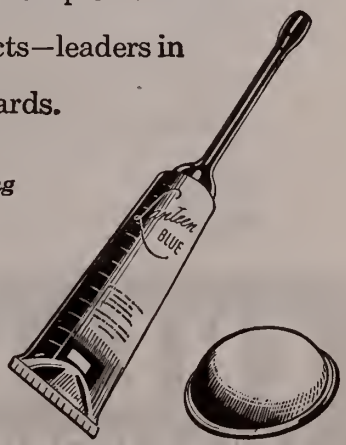
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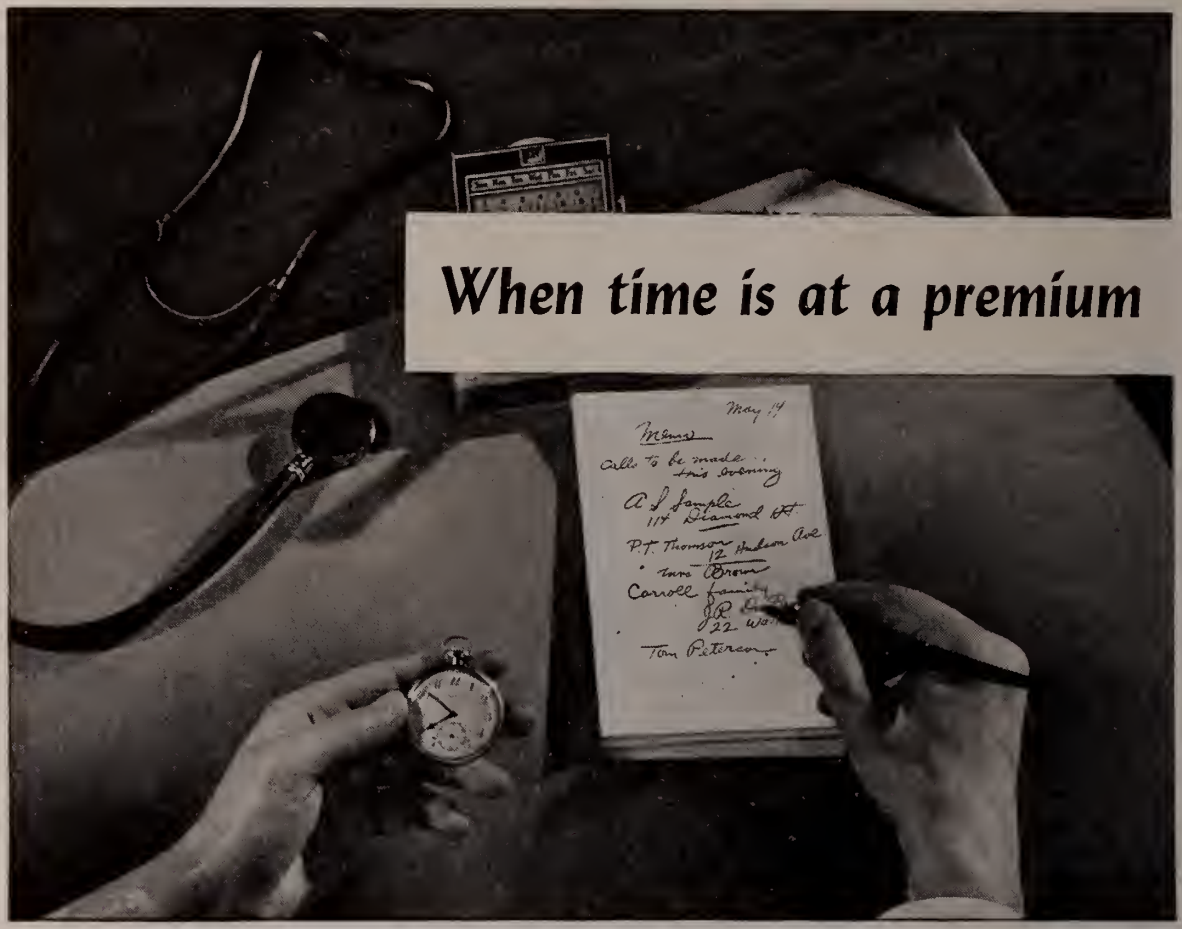




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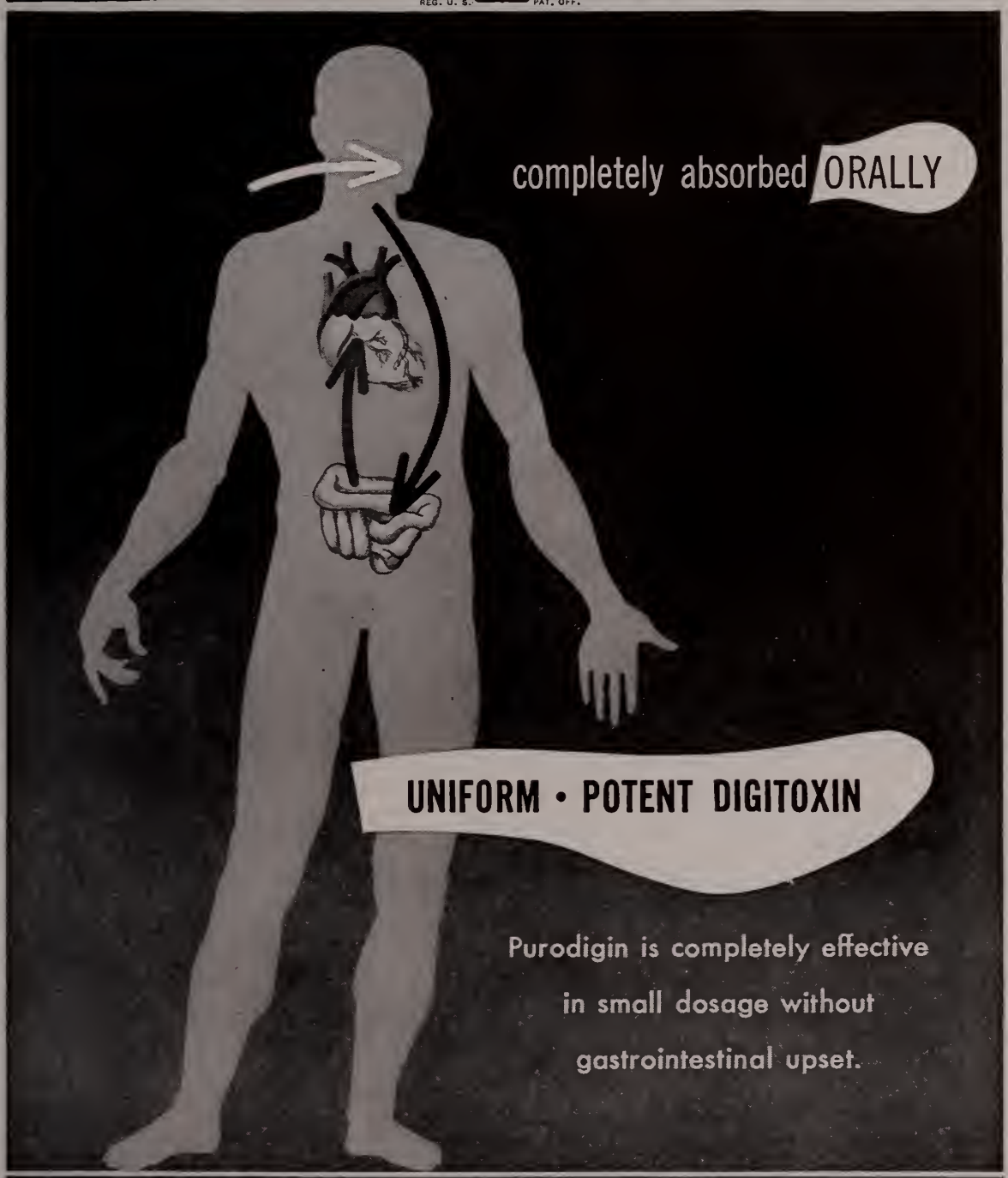
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Book Reviews

SYMPTOMS OF VISCERAL DISEASE: A Study of the Vegetative Nervous System in Its Relationship to Clinical Medicine: By Francis Marion Pottenger, A.M., M.D., LL.D., F.A.C.P., Medical Director, Pottenger Sanatorium and Clinic for Diseases of the Chest, Monrovia, California; Professor Emeritus of Clinical Medicine, University of Southern California; Author of "Clinical Tuberculosis," "Tuberculin in Diagnosis and Treatment," "Muscle Spasm and Degeneration" etc. Sixth Edition. With Eighty-seven Text Illustrations and Ten Color Plates. St. Louis. The C. V. Mosby Company, 1944. Price $5.00.

This, the sixth edition of a book first published in 1919, has been brought entirely up to date, and as stated by the author, his excuse for revising the book is primarily the fact that there is an ever-growing interest in visceral neurology. Basically a study of the vegetative nervous system in its relationship to clinical medicine, it is intended to aid in interpreting symptoms usually considered as of a reflex nature.

The book is divided into three parts; the first dealing with the vegetative nervous system giving general considerations, anatomical considerations, location and functions of vegetative centers in the central nervous system, physiologic considerations and other allied subjects.

The second part deals with the relationship between the vegetative nervous system and the symptoms of visceral disease giving in detail the basis of classification of symptoms of disease, symptoms due to toxemia, viscerogenic reflex, visceral pain, and a study of various reflexes as well as sympathetic and parasympathetic syndromes.

The third part discusses the innervation of important viscera with a clinical study of the more important viscerogenic reflexes. The innervation, clinical considerations and reflexes of the important body structures are considered in turn. The author endeavors to present data to bring together the cause and effect in certain disease processes.

It is quite obvious as one looks over this book that those who will take the time to give it the attention it justly deserves, will profit greatly, and no doubt will be able to solve many of the problems he has been facing in his clinical work, and be able to discover why certain symptoms are present and the likely cause of them.

The book has eighty-seven text illustrations and ten color plates which add materially to its value to the reader.

THE ART OF RESUSCITATION: By Paluel J. Flagg, M.D. Chairman, Committee on Asphyxia, American Medical Association; President and Founder of the Society for the Prevention of Asphyxial Death, Inc.; Director of Pneumatology, New York World's Fair, 1939, Inc.; Author, "Art of Anaesthesia"; Visiting Anaesthetist, Manhattan Eye and Ear Hospital; Consulting Anaesthetist to St. Vincent's Hospital, The Woman's Hospital, Sea View Hospital, Jamaica Hospital, Mount Vernon Hospital, Flushing Hospital, Mary Immaculate Hospital, St. Mary's Hospital, and Nassau Hospital. Reinhold Publishing Corporation, 330 West Forty-second Street, New York, 1944. Price $5.00.

With a foreword by Chevalier Jackson in which it is predicted that the book will have wide circulation, the author states that the purpose of the book is to attempt to tell the reader what to do when faced by an acutely asphyxiated patient about to die. The information is based upon more than twenty-five years of experience on the part of the author who has seen many cases of asphyxia, and has faced the dilemma referred to so frequently.

The book is divided into eight parts dealing with such important subjects as Asphyxia as a General Problem; The Principles of Resuscitation; Asphyxia as a Specific Problem; The Field of Asphyxia and Resuscitation; The Coordination of Gas Therapy; then a miscellaneous section in which instructions of technicians, asphyxia neonatorum and judicial electrocution are discussed in much detail.

Chapter six on Methods of Resuscitation should be of interest to all physicians and especially to those who are called upon to give emergency care in asphyxiated individuals. The popular and generally accepted methods are described and well illustrated. Likewise essential apparatus to aid in resuscitating these patients has received much consideration. Excellent

(*Continued on page* 52)

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BOOK REVIEWS (Continued)

tips on the selection of resuscitation apparatus are given which should be of much value to everyone.

The book is profusely illustrated which adds materially to its value. This volume should be in the hands of physicians everywhere as it contains detailed information on a highly important subject of general interest.

THE MANAGEMENT OF OBSTETRICAL DIFFICULTIES: By Paul Titus, M.D., Obstetrician and Gynecologist to St. Margaret Memorial Hospital, Pittsburgh; Consulting Obstetrician and Gynecologist to the Pittsburgh City Homes and Hospital, Mayview, and to the Homestead Hospital, Homestead, Pa.; Secretary of the American Board of Obstetrics and Gynecology; Commander (MC) USNR, attached to Professional Division, Bureau of Medicine and Surgery, Navy Department, Washington, D.C., with 426 Illustrations and 8 Color Plates. Third Edition. St. Louis. The C. V. Mosby Company, 1945. Price $10.00.

Dr. Titus brought out the first edition of this book in 1937 and it was revised and reprinted again in 1940. With constant changes in obstetric practice as with other branches of medicine, the book was brought into its third edition this year with extensive changes.

Although covering in a general way the field of obstetrical practice, special attention should be called to the inclusion of penicillin as used in obstetrical and gynecological practice, as well as the use of the sulfonamides, and especially the types which have appeared since the last edition of the book was published.

X-ray pelvimetry and its present day value in obstetrical work is properly outlined in much detail. This is rapidly becoming one of the essentials in modern obstetrics. As would be expected, the Rh factor and its incompatibilities and erthroblastosis are presented and brought up to date. The chapter on anesthesia is most interesting and complete, and includes the latest evaluation of caudal anesthesia in obstetric practice.

Intravenous infusions and transfusions are given proper consideration in a chapter completely rewritten for this edition. The author has long believed that there is such a close relationship between obstetrics and gynecology that the textbook on obstetrics and obstetrical complications should likewise include many gyneclogical conditions which frequently are a factor in the production of complications.

With 426 illustrations and 8 color plates to add to its value, this book will unquestionably be of much value to obstetricians as well as the practitioners who are compelled to do obstetrical work along with the many other ramifications of medical practice. It should have a place in any modern medical library.

BEDSIDE CLINICS OF FRANCIS D. MURPHY, M.D., F.C.A.P., Professor and Head of the Department of Medicine of the Marquette University Medical School and Clinical Director of the Milwaukee

(*Continued on page* 54)



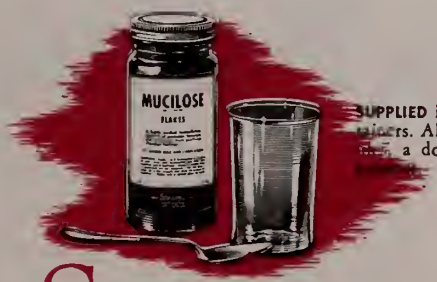
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*Gray, H and Tainter, M L.; *Am J Digest Dis* 8:130, 1941

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BOOK REVIEWS (Continued)

County General Hospital and Emergency Unit. Volume I. Milwaukee. Marquette University Press. 1945.

A few years ago Doctor Murphy wrote a series of Bedside Clinics, the last number of which was published about five years ago. In starting a new series, he had in mind for the first volume, discussing disorders which had not been taken up previously. In a rather unique manner, the author presents an illustrative case then briefly the methods of approach in reaching the diagnosis.

He appropriately considers first the heart starting with acute coronary thrombosis, then in turn, essential hypertension, blood, metabolic disturbances, nervous system, lung, abdomen, kidney, liver, diseases of obscure origin, peritonitis, then the subject of penicillin, ending the volume with an article on renal damage due to sulfonamides.

Like other modern books on clinical subjects, the reader will find much of interest and value, and a fascinating story in connection with each presentation. Doctor Murphy's discussion of chest pain and its differential diagnosis will be of interest to all physicians who read it. He has condensed a highly important subject to present it ably in only a few pages.

Bibliographic references are given at the end of each subject, which will appeal to many who are interested in this literature.

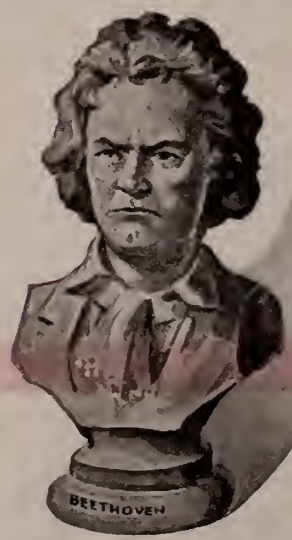
The reviewer predicts that the Bedside Clinics will become very popular with the medical profession, and that those reading them will look forward to recieving the various volumes as they appear.

CONTROL OF PAIN IN CHILDBIRTH: Anesthesia, Analgesia, Amnesia: By Clifford B. Lull, M.D., F.A.C.S., Clinical Professor of Obstetrics, Jefferson Medical College; Assistant Director, Philadelphia Lying-In Unit, Pennsylvania Hospital; and Robert A. Hingson, M.D., Surgeon, U. S. Public Health Service; Director, Post-graduate Medical Course, Philadelphia Lying-In Unit, Pennsylvania Hospital. With an introduction by Norris W. Vaux, M.D., Obstetrician in Chief, Philadelphia Lying-In Unit, Pennsylvania Hospital. 100 illustrations in black and white and 32 subjects in color. J. B. Lippincott Company, Philadelphia and London, 1944. Price $7.50.

For many years physicians have been endeavoring to develop methods of alleviating pain in childbirth. During the past century many anesthetics and algesic remedies have been tried out with some success. With the development of the gas anesthetic apparatus and

(*Continued on page* 56)

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BOOK REVIEWS (Continued)

its administration during labor much relief has been given.

More recently has come caudal analgesia which has been widely used and promises to give more relief from pain than perhaps any of the other methods so far tried. The authors having reviewed much recent literature on the subject, have developed this book to give the various techniques which have been used in the administration of anesthetics, analgesics, or as they state, "The problems of analgesia, amnesia and anesthesia in obstetrical practice."

They give the effects of the various drugs on mother and child, indications and contraindications for their use, select the type of pain relief best suited for the individual patient considering the mother's physical condition and emotional status, then the simplification of the technique to be used to give the greatest amount of relief from pain and to best safeguard both mother and child.

The book is divided into three parts. The first dealing with the anatomy of the organs of parturition; physiopharmacology of the general anesthetic and amnesic agents; physiopharmacology of paravertebral, peridural, regional, local, spinal, caudal and continuous caudal analgesia and anesthesia in obstetrics.

Part two gives critical consideration to the history of pain relief during childbirth, technique for the relief of pain during labor and delivery, management of the third stage of labor, caesarean section, management of the puerperium and choice of the agent of pain relief in home obstetrics.

Part three covers the control of pain in maternal complications, methods and drugs used in the resuscitation of the newborn.

This is a valuable compilation of the voluminous literature and shows unmistakable efforts on the part of the authors to coordinate and correlate the knowledge available and make it readily accessible in one book for those doing obstetrical work. It should be of much interest to all physicians desirous of keeping up with the times on this important subject.

Books Received

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

A Synopsis of Medicine: Sir Henry Letheby Tidy, K.B.E., M.A., M.D., B.Ch. (Oxon), F.R.C.P. (Lond.) Extra Physician to H.M. The King; Consulting Physician to St. Thomas's Hospital; Hon. Major-General, lately Consulting Physician to the

(*Continued on page* 58)

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*"Bactericidal Efficiency of Iodine Solutions and Organic Mercurial Antiseptics", Amer. Jour. Pharm., 117:5 (Jan.) 1945.

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★ ★

BOOKS RECEIVED (Continued)

British Army. Eighth Edition Revised and Enlarged. A William Wood Book. The Williams and Wilkins Company, Baltimore, 1945.

A Manual of Surgical Anatomy; Prepared Under the Auspices of the Committee on Surgery of the Division of Medical Sciences of the National Research Council. By Tom Jones and W. C. Shepard. W. B. Saunders Company, Philadelphia and London, 1945. Price $5.00.

Clinical Traumatic Surgery: By John J. Moorhead, B.S., M.D., D.Sc., F.A.C.S., (D.S.M.) Formerly Professor of Clinical Surgery, New York Post-Graduate Medical School, Columbia University, and Executive Officer, Department of Traumatic Surgery, Post-Graduate Hospital and Reconstruction Hospital Unit; Diplomate in Surgery; Colonel, Medical Corps (A.U.S.) Inac. Res.; Medical Director, New York City Transit System. Consulting Surgeon, Post Graduate Hospital, U. S. Public Health Service, All Souls (Morristown), Anne May Memorial (Spring Lake), Caledonian, Harlem, Mary Immaculate (Jamaica), Mother Cabrine, New Rochelle, Nyack, Rockland State, St. Francis (Port Jervis), and Yonkers General Hospitals. 747 pages with 500 illustrations. Philadelphia and London: W. B. Saunders Company, 1945. Price $10.00.

Hayfever Plants: Their Appearance, Distribution, Time of Flowering, and their Role in Hayfever with special Reference to North America: By Roger P. Wodehouse, Ph.D., Associate Director of Research in Allergy, Lederle Laboratories, Pearl River, N. Y. Waltham, Mass., The Chronica Botanica Company, New York City. G. E. Stechert and Company. Price $4.75.

National Health Agencies: A Survey With Especial Reference to Voluntary Associations. By Harold M. Cavins. Including a Detailed Director of Major Health Organizations. Public Affairs Press. American Council on Public Affairs, 2153 Florida Avenue, Washington 8, D. C., Price $3.00.

Rypin's Medical Licensure Examinations: Topical Summaries, Questions, and Answers. Fifth Enlarged Edition Completely Revised Under the Editorial Direction of Walter J. Bierring, M.D., F.A.C.P., M.R.C.P., Edin. (Hon.) Member, National Board of Medical Examiners; Secretary, Federation of State Medical Boards of the United States. With the Collaboration of a Review Panel. J. B. Lippincott Company, Philadelphia, 1945. Price $6.00.

Proteins and Amino Acids — Physiology, Pathology and Therapeutics: Prepared for Distribution to the Medical Profession by the Arlington Chemical Company, Yonkers, New York.

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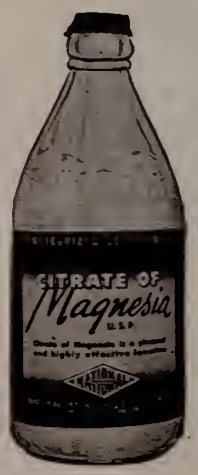
The use by propagandists of incomplete statements regarding various aspects of the nation's health in support of proposed changes in methods of medical practice is condemned by *The Journal of the American Medical Association* for April 28. The *Journal* says:

"Among the major annoyances to American physicians of the last decade have been the loose statements emanating from propagandists in support of proposed changes in methods of medical practice. The death rates in the United States, although they are among the lowest if not the lowest of any great nation in the world, are always described as 'shocking' or 'amazing.' We are told again and again that one third or more of American youths are physically unfit, but they never say physically unfit for what or by what standard. This type of viewing with alarm has now aroused the satire of a writer for the New York *Times*. He says in a recent issue that there is one indispensable rule for viewing with alarm and that is, when quoting, never to use conditional or supplementary clauses. His first example is a statement recently syndicated under a Washington dateline: 'Only one American in a thousand is really well fed.' Now actually Americans are today about the best fed people in the world. This does not mean to say that the modern advances in the science of nutrition are universally applied. That will no doubt involve a long process of education. No one has yet discovered a technic for overcoming completely the cultural lag between the acquisition of knowledge and its extension to the remotest individual in the population. The truth about nutrition is expressed in the following, which is the whole sentence: 'Only one American in a thousand is really well fed, in the sense that no further improvement in his physical condition could be made by changes in his diet.'

"Innumerable Americans have been startled in the last three years by the amazing misuse of the statistics coming from the Selective Service System and repeatedly quoted by writers in the press and in the reports of various governmental committees. Even Senator Pepper's Interim Report of the Committee on Education and Labor of the U. S. Senate emphasized the statistics although they did use also the saving statement that we are not obviously a nation of weaklings. The writer for the New York *Times* calls attention to the statement 'Only one American in ten thousand can really be said to boast of a proper physique.' This is a startling indictment, but the sentence, to be finished honestly, must include the clause 'taking the Apollo Belvedere as a standard.' Scientific writers have emphasized again and again that the examination of millions of young men was conducted for a specific

(*Continued on page* 62)

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LOOSE STATEMENTS (Continued)

purpose—to obtain an army. Moreover, the standards of induction varied from time to time, beginning with an exceedingly high standard when we were concerned with the raising of an army of a million men for training and proceeding to a somewhat lower standard, involving the acceptance of men with manifest disabilities, when it became necessary to scrape the bottom of the barrel. Under the heading 'This Nation's Health' the New York *Times* commentator says:

That second example of what we may call the missing conditional clause is no doubt considerably exaggerated. But in kind if not in degree it is in the same class with so many statements about the positively frightening percentage of American school children who suffer from physical defects, said "defects" often consisting of troublesome tonsils or a couple of tooth cavities or three pounds under weight. It applies, though in less degree, to the large percentage of men disqualified for military service, where the emphasis on "military" is slighted and then entirely forgotten. We end up by speaking of the American nation as 25 percent physically unfit.

"Similarly we must analyze more scientifically all of the figures now being developed relating to what are called neuropsychiatric disabilities or defects. Many experts are convinced that a large percentage of those who are classified neuropsychiatric under military conditions are able to live efficient, satisfactory lives as civilians in the occupations to which they are adapted. A psycologist has pointed out that the age of 16 years is taken as a maximum for mental sufficiency, so that we need not be alarmed if we are called a nation of 14 year old or 12 year old mentalities. If Thomas Jefferson and Winston Churchill are classified as 16's, the rest of us can be reasonably satisfied to be called 14's.

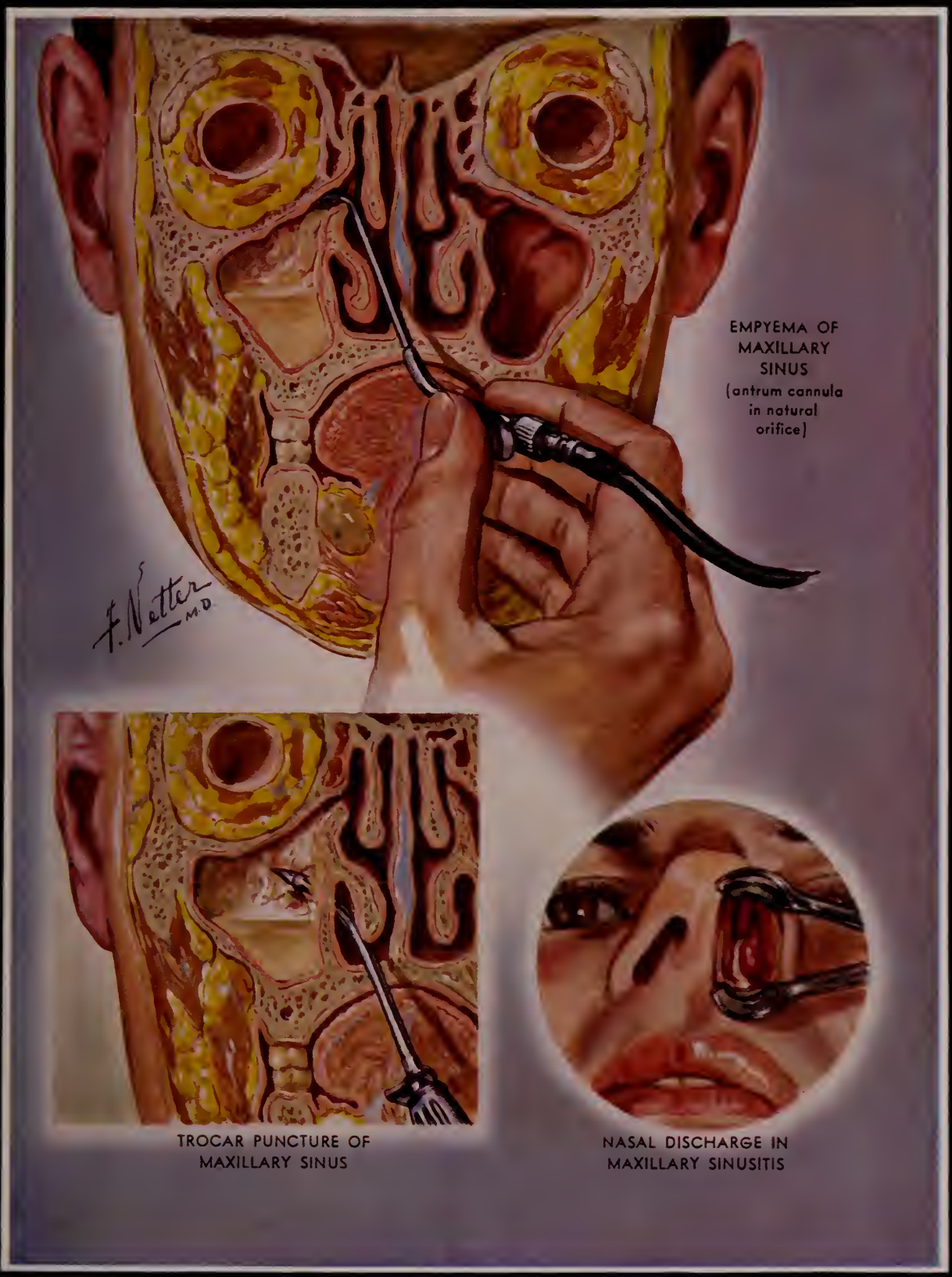
"Not every one is capable of evaluating scientifically the startling statements made by those who would strike fear as part of a propaganda to secure change. Quoting again:

". . . It is dynamic to say that Americans are really not well fed, if the plain duty of nutrition is to turn us all into Discus Throwers and Venus de Milos, into Johnny Weissmüllers and Babe Diedricksens.

The usual retort is that in order to get people to do things you must throw a scare into them. And yet President Roosevelt said that the only thing we have to fear is fear itself."

In terms of practical management, pulmonary tuberculosis can be as much a disease of the personality as it is of the lungs. Jerome Hartz, M.D., Psychosomatic Medicine, January, 1944.

He said true things, but called them by wrong names.—*Robert Browning*



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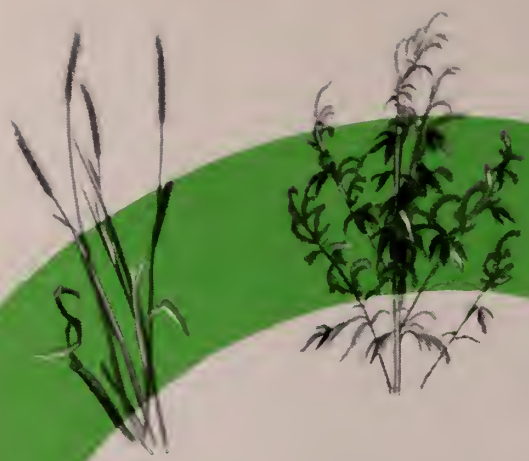
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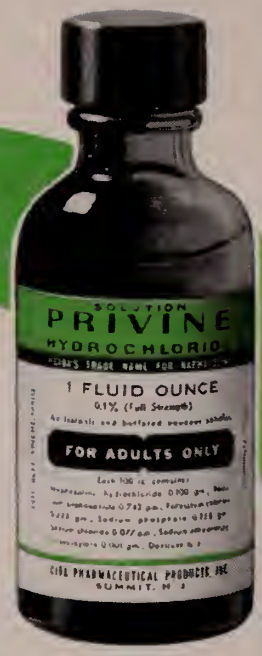
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JOURNAL SAYS 6,933 ARE ADDED TO U. S. PHYSICIAN RANKS IN 1944

Death Removes 3,627 Doctors, 245 More Than 1943; Estimate 100,000 Are In Private Medical Practice

There were 6,933 additions to the medical profession in 1944, according to data presented in the forty-third annual compilation of medical licensure and allied statistics by the Council on Medical Education and Hospitals of the American Medical Association and published in *The Journal* of the Association for May 12.

This number, *The Journal* says, is "the largest added to the profession for many years, including the years 1936 to 1941 when large numbers of foreign graduates were licensed and added to the profession in this country. The number of foreign graduates licensed was fewer than at any other time since 1935."

The newest compilation shows that the number of physicians removed by death in 1944 was 3,627, which was 245 more than in 1943.

From these figures it would appear that the physician population in the United States during 1944 was increased by 3,306. "Many more than this latter number," the report explains, "were added to the armed forces as medical officers in 1944, so that there has resulted an actual decrease in physicians available to civilians in the course of the year. In view of the accelerated program, one might expect that additions to the profession would be considerably higher. While two classes were graduated from most medical schools

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in 1943, the number of phsyicians added to the profession in that year did not increase, since many physicians who obtained M.D. degrees in December of that year were not able to receive licenses until early in the year 1944, owing to administrative details. In 1944 the number in this group was 979 more than in the previous year. . . .

"Estimated figures indicate that on Jan. 1, 1945 the number of physicians in continental United States, including those licensed in 1944 was 191,689. Excluding physicians who are in military service, engaged in full time hospital work, retired, engaged in full time teaching or not in practice, there remain approximately 100,000 physicians in private practice, some of whom are part time teachers. . . ."

During the year 1944, 9,606 licenses to practice medicine and surgery were issued by the medical examining boards of the forty-eight states, the District of Columbia, Alaska, Puerto Rico and the Virgin Islands. Of the 9,606 licenses issued, 7,035 were issued after examination and 2,571 by reciprocity agreements or by the endorsement of other state licenses or the certificate of the National Board of Medical Examiners.

The greatest number of licenses during the calendar year 1944 was issued in California, with 912. Three other states licensed more than 700: Pennsylvania 898, Ohio 837 and New York 788. Twenty-two states, the District of Columbia and the territories and possessions licensed fewer than 100. None were licensed by

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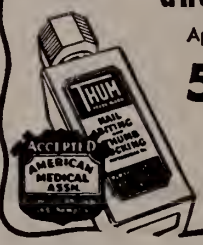
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examination in Wyoming. The least number of licenses was issued in North Dakota, totaling 7.

Twenty-three approved schools in the United States had no failures before medical licensing boards, thirty-two approved schools had less than 5 per cent and six approved schools between 5 and 10 per cent. While no compilation of recent graduates has been made, only 2.9 per cent of the 5,432 graduates of the approved medical schools in the United States failed during the calendar year 1944.

Failures exceeded 45 per cent among the graduates of unapproved medical and osteopathic schools examined by medical examining boards.

Commenting on the comparative failures, *The Journal* says editorially: "The inadequacy of the educational programs of unapproved schools is clearly reflected in an analysis of failures in licensing examinations. . . ."

A SPOT ON THE LUNG

It is futile to search in dictionaries or medical text-books for a definition of the term "a spot on the lung." But the term is being used with great frequency by physicians, nurses and laymen alike. If this term is subjected to scrutiny, it is found that it may mean anything and everything that produces either a shadow or an area of decreased density in a chest roentgenogram or anything and everything that causes abnormal physical signs over the lungs. If, then, this expression has no meaning that cannot be stated more precisely in other terms, it remains to be found out why it is being used. If this is one of the terms that does not express a definite meaning, does it possibly obscure a meaning?

Nobody who has searchingly studied the histories of patients with pulmonary disease can doubt that the real function of the phrase, "a spot on the lung," is to cloud the facts. It is a cloak for a great variety of pulmonary diseases, a protective screen for the inability or unwillingness of the physician to arrive at a diagnosis acceptable to himself, a disguise for a bitter truth that the physician hesitates to tell the patient, an escape for the patient who tries to elude further diagnostic work and necessary treatment. After all, one does not die of "a spot on the lung," but one can die of bronchial carcinoma and one might die of pulmonary tuberculosis. Along with much other evasive, medical double-talk, "a spot on the lung" is a verbal mechanism of escape from reality. In the same category belongs the term "a touch of tuberculosis" and, improperly applied, "nothing but a little thickened pleura."

No physician needs to be told that " a spot on the lung" is no diagnosis. He realizes that it is evidence, on the one hand, of healed disease which calls neither for treatment nor for alarming its bearer, or, on the other, of active disease in need

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of treatment. The physician sometimes uses the term in patients in whom he has failed to establish, with a certainty that carries conviction for himself, the difference between active disease and obsolete scar. "A spot on the lung" has a pleasantly innocent sound. It lulls into inertia and indifference whatever doubts or curiosity the patient, and, even in some cases, the doctor may have. But still it is, for the physician, a mental reservation. It seems to beckon as a safe place to stand if "a spot on the lung" later turns out to be carcinoma, tuberculosis or bronchiectasis.

Admittedly, this judgment may be harsh. But I dare say that it will be resented only by those who, with the instrumentality of this ambiguous term, neglect their obligation of persevering until "a spot on the lung" has been accurately diagnosed. No person need be told that he has "a spot on the lung." If the condition is as clinically insignificant as the term suggests, the patient should be told that he has a scar from a previous tuberculous infection — one that needs an occasional check-up or one that needs no further observation. Or when the diagnosis is certain, the patient should be told that his lungs are normal. For, while "a spot on the lung" is often the obscured beginnings of destructive disease, it is, in other cases, the starting point for tuberculophobia and anxiety neuroses, conditions that are no less crippling

(*Continued on page 70*)

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A SPOT ON THE LUNG (Continued)

and hardly more easily curable than tuberculosis itself.

But, though every reflecting physician knows that "a spot on the lung" is a meaningless and dangerous term, the utter convenience of the expression—and others like it—militates against their prompt extinction. Past experience justifies a pessimistic outlook. No amount and intensity of medical education are likely to eliminate entirely the term from medical parlance. Medical education however is being overtaken by the information that the public, including the prospective patient, is acquiring. People are learning to realize fully the confusing ambiguity of the term, they are beginning to refuse its acceptance just as an enlightened consumer protests against ambiguous and misleading labels on packaged goods. And the comparison is eminently proper: for all intents and purposes, "a spot on the lung" *is* ambiguous and misleading labeling. It may well be that through the protest of the consumer, by the refusal of every layman to be satisfied with the pseudo-diagnosis of "a spot on the lung" the term will eventually disappear.

It is high time for the medical and nursing professions and everyone engaged in tuberculosis work to bury a medical term that has quite literally buried so many patients.

A Spot on the Lung, Max Pinner, M.D., The NTA Bulletin, January, 1945.

PENICILLIN IS USED TO TREAT BABIES WITH RAT BITE FEVER

Four babies, all under six months of age, were treated successfully for rat bite fever with penicillin, Warren E. Wheeler, M.D., Detroit, reports in the April issue of the *American Journal of Diseases of Children.* The treatment of infections due to rat bites thus far has been unsatisfactory. The sulfonamide compounds have no effect on the microbes causing the infections, and treatment with the arsenicals has given doubtful results. Doses of 5,000 units of penicillin were injected intramuscularly into the four babies every two to three hours for a week to 10 days. This seemed sufficient, the physician stated, to control the rat bite infection.

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The ILLINOIS Medical Journal

VOL. 88 NO. 2

August, 1945

In This Issue

Hospital Care For the Patient with Acute Poliomyelitis

Mental Illness As A Post War Public Health Problem

(See page 33 for complete Table of Contents)

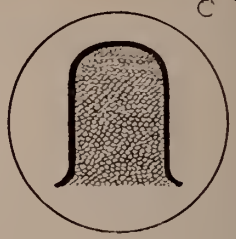
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1. HYPO-EPITHELIUM (*a decrease in the number of cell layers composing the vaginal mucous membrane, due to inflammatory hyper-desquamation*).

FLORAQUIN by allaying the inflammatory reaction, destroying the pathogenic organisms and providing carbohydrates for mucosal glycogen, facilitates regeneration of the mucosa to normal.

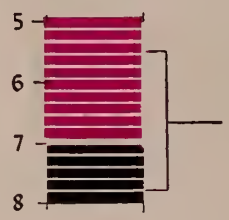




2. HYPO-GLYCOGEN (*due to a marked decrease in the number of glycogen bearing cells of the vaginal mucous membrane*).

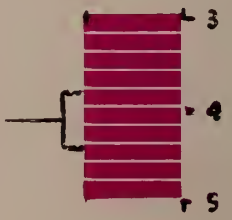
FLORAQUIN makes available carbohydrates, lactose and dextrose, for absorption by the regenerating vaginal epithelium, and storage in the form of glycogen.





3. HYPO-ACIDITY (*usually the vaginal pH is close to neutral, or even alkaline—pH 5.5 to 7.8*).

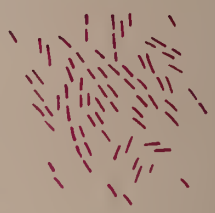
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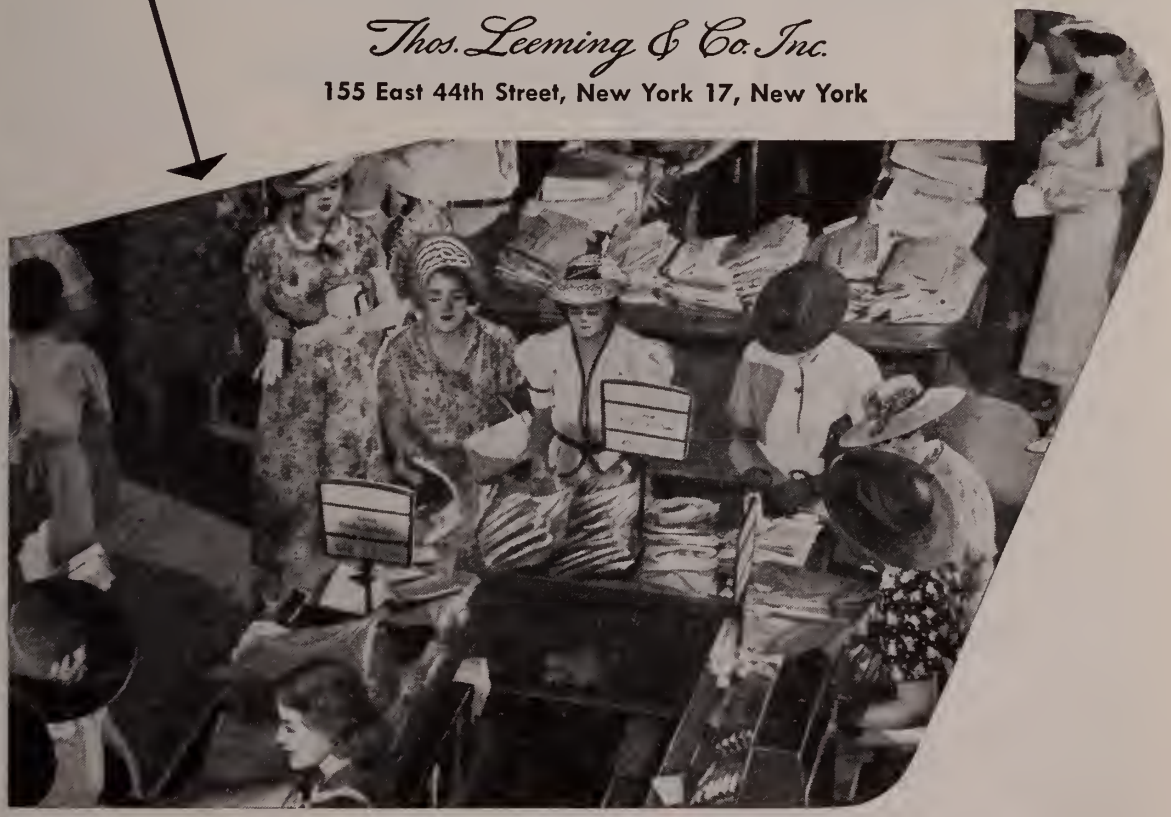
Entered as Second-Class Matter July 21, 1919, at the Post Office, Oak Park, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate of postage provided for in Section 1102, Act of October 8, 1917, authorized July 15, 1918, Office of Publications, 715 Lake Street, Oak Park, Ill.

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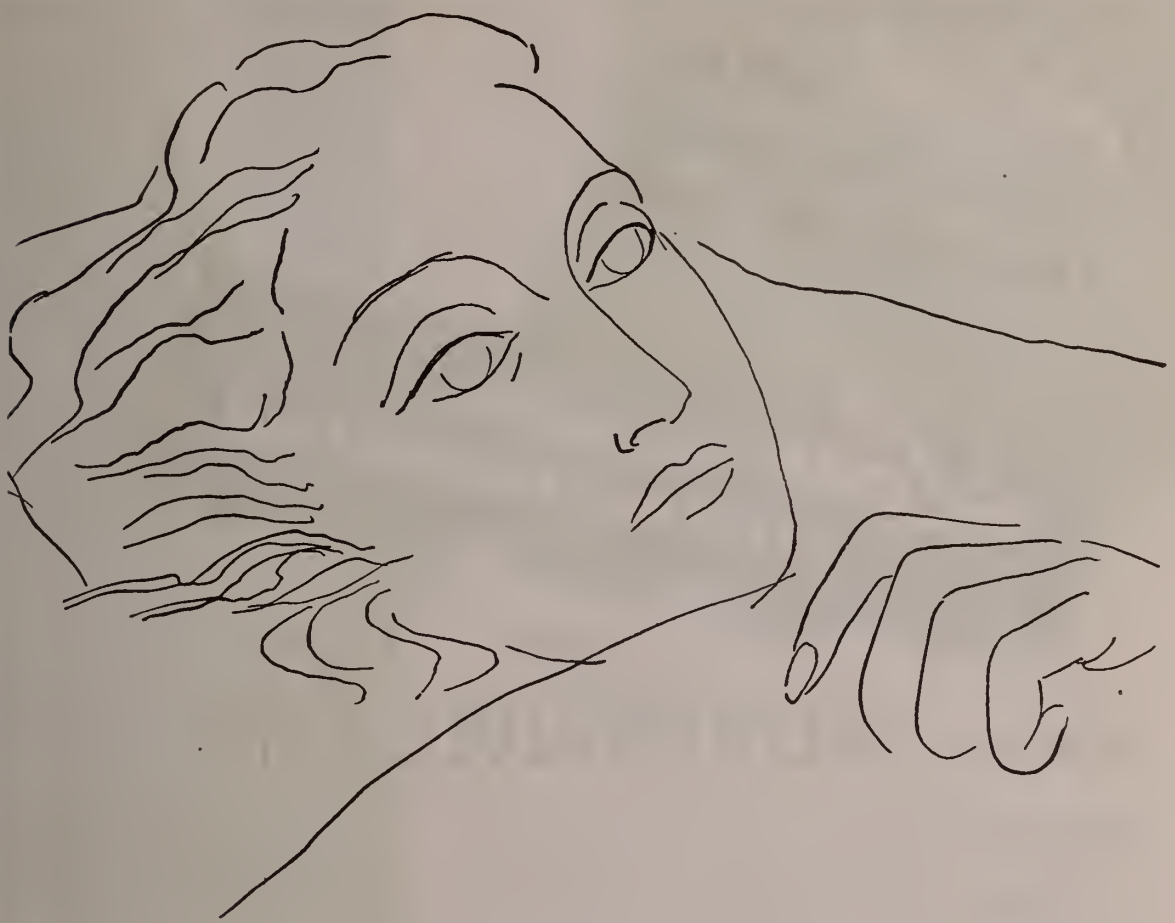
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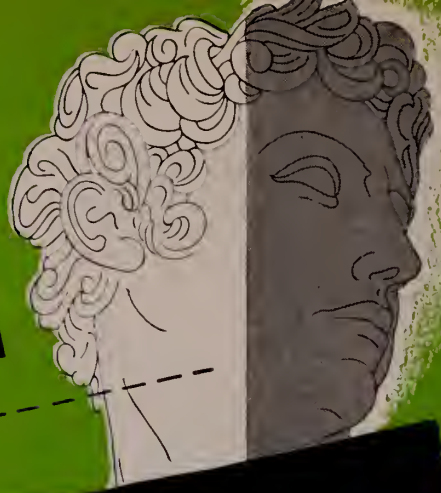
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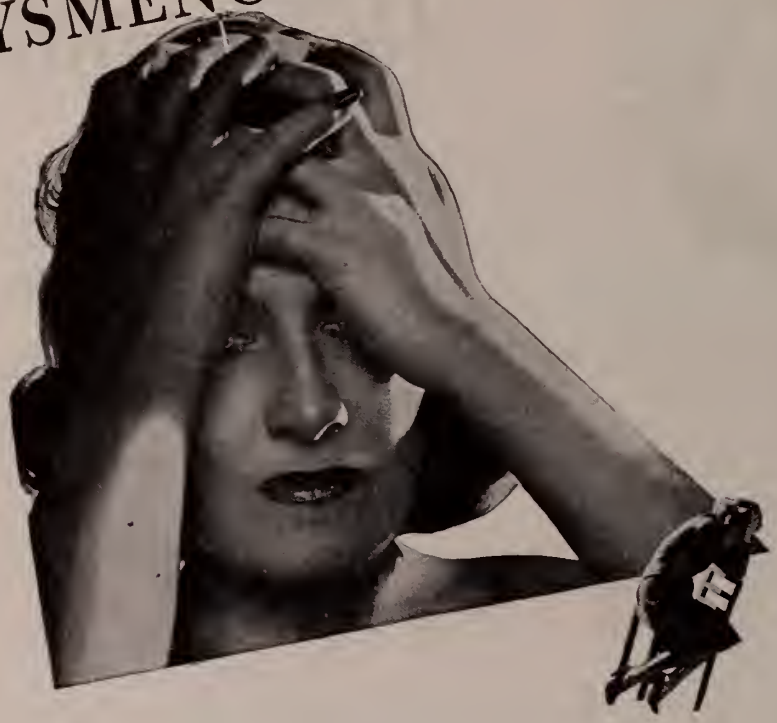
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DYSMENORRHEA



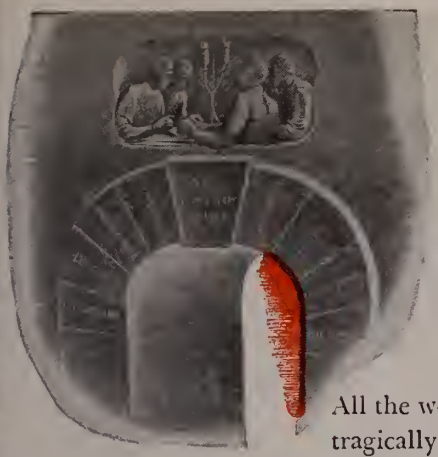
"A more rational approach seems to be indicated in treating dysmenorrhea by attempting to raise the pain threshold, or in some other way, block the sensory pathways to the higher centers of the brain."*

*Kroger, W. S., and Freed, S. C.: Am. J. Obst. & Gynec. 46:817 (December), 1943.

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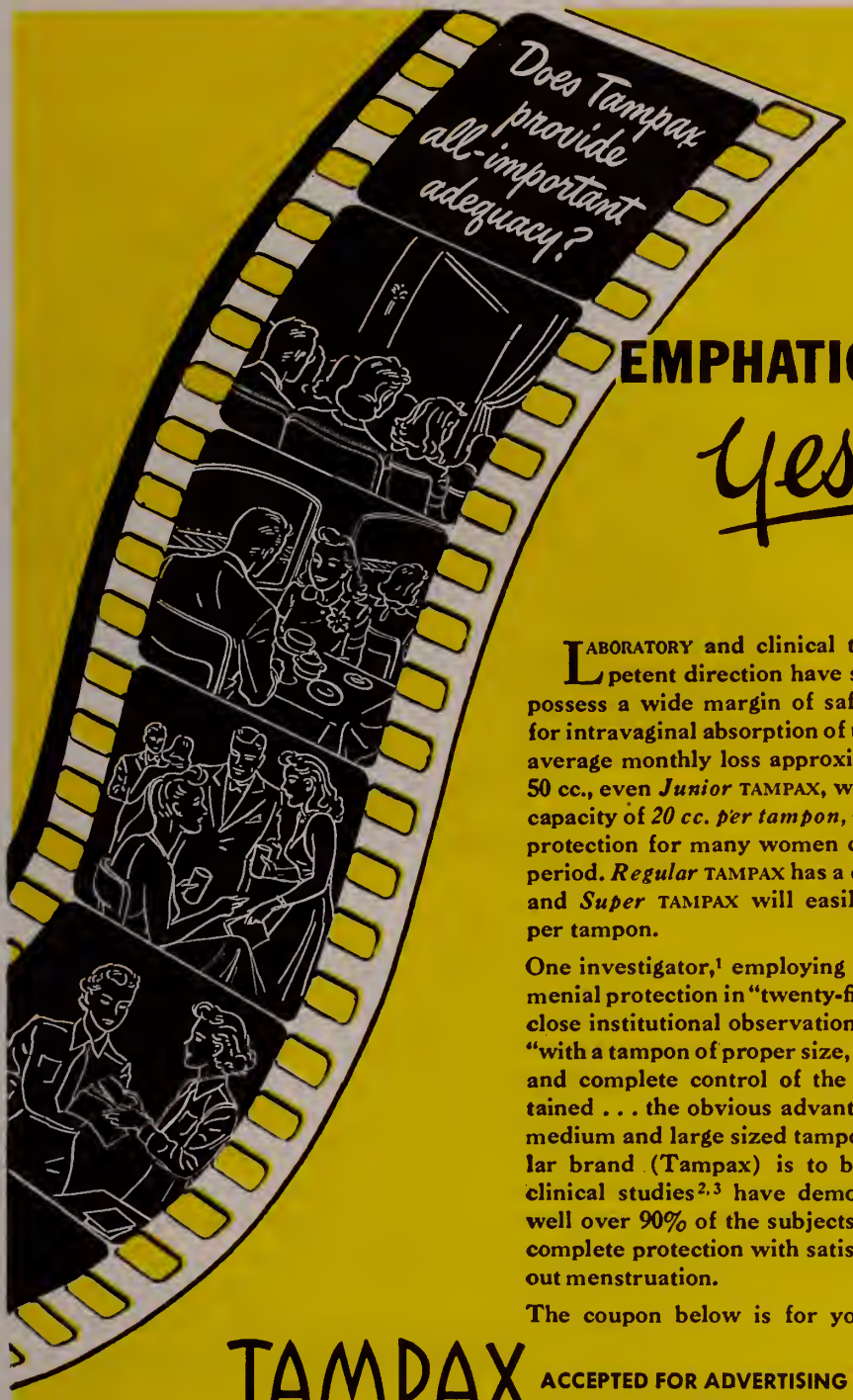
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REFERENCES: 1. Med. Rec., 155:316, 1942. 2. West. J. Surg., Obst. & Gynec., 51:150, 1943. 3. Clin. Med. & Surg., 46:327, 1939.

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— EDITORIAL J.A.M.A., 120: 536 (OCT. 17) 1942

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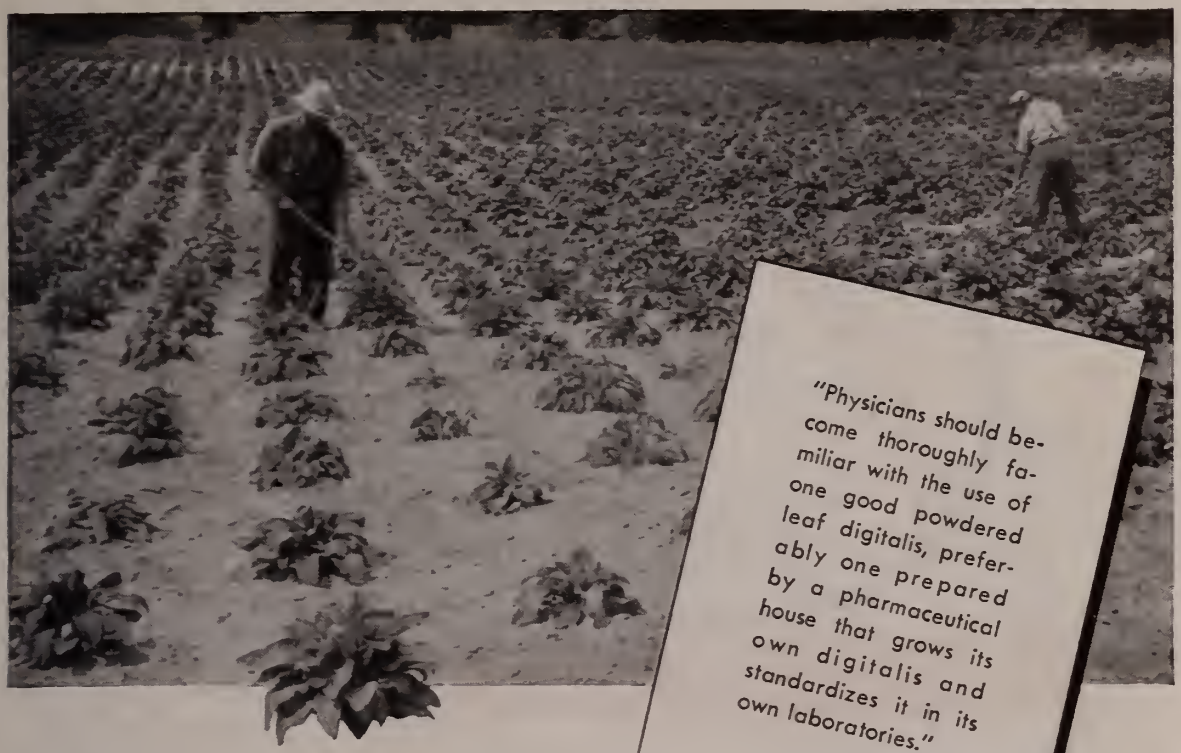
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*J. K. Quigley, Am. J. Obst. & Gynec., 49:633, 1945



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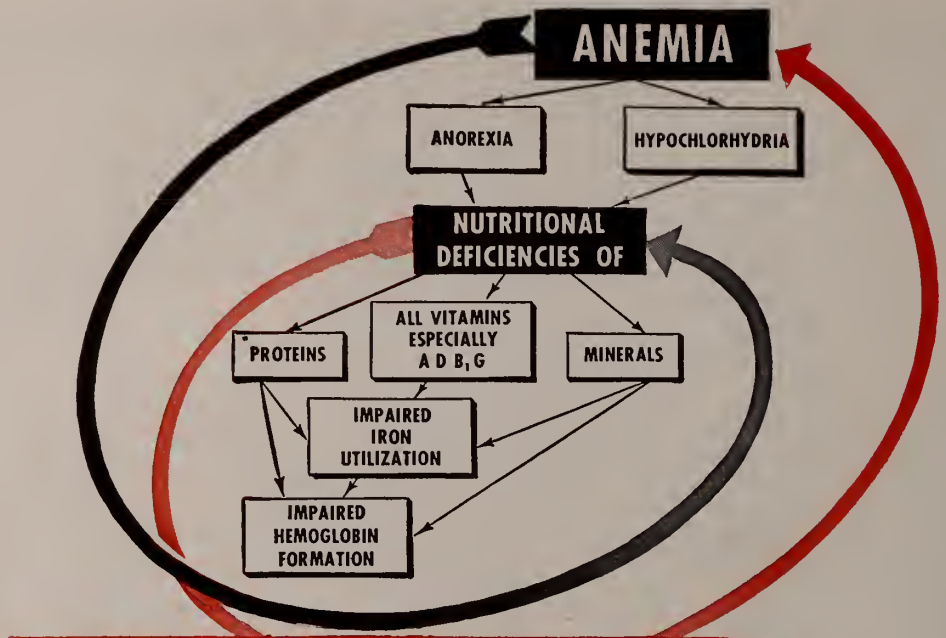
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1. Herrmann, G. R.; Decherd, G. M. Jr., and McKinley, W. F.; Digitalis Poisoning, J.A.M.A. 126:760 (Nov. 18) 1944.

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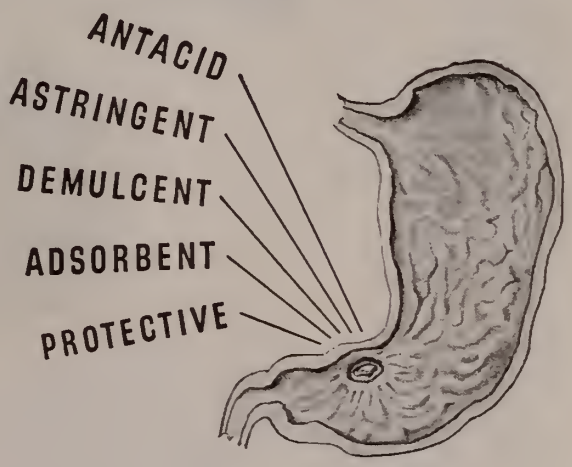
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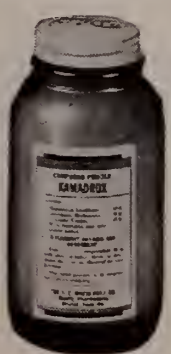
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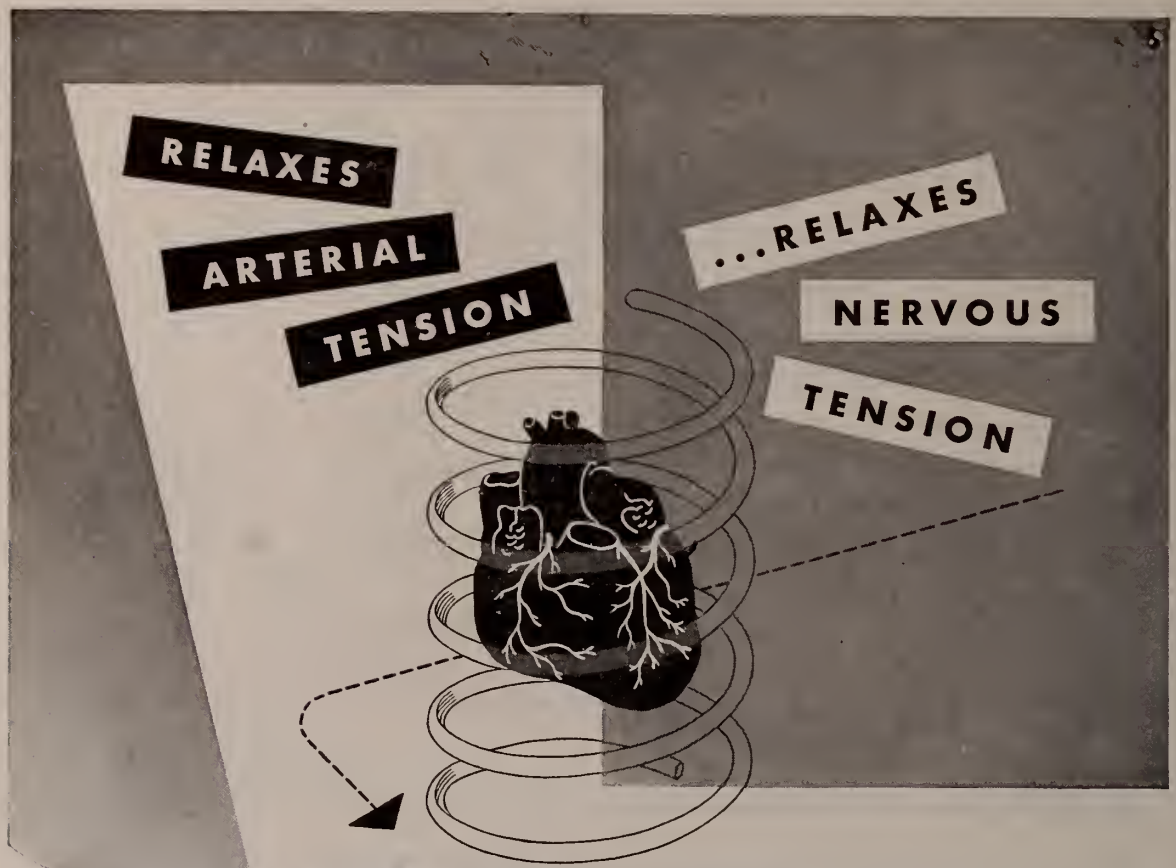
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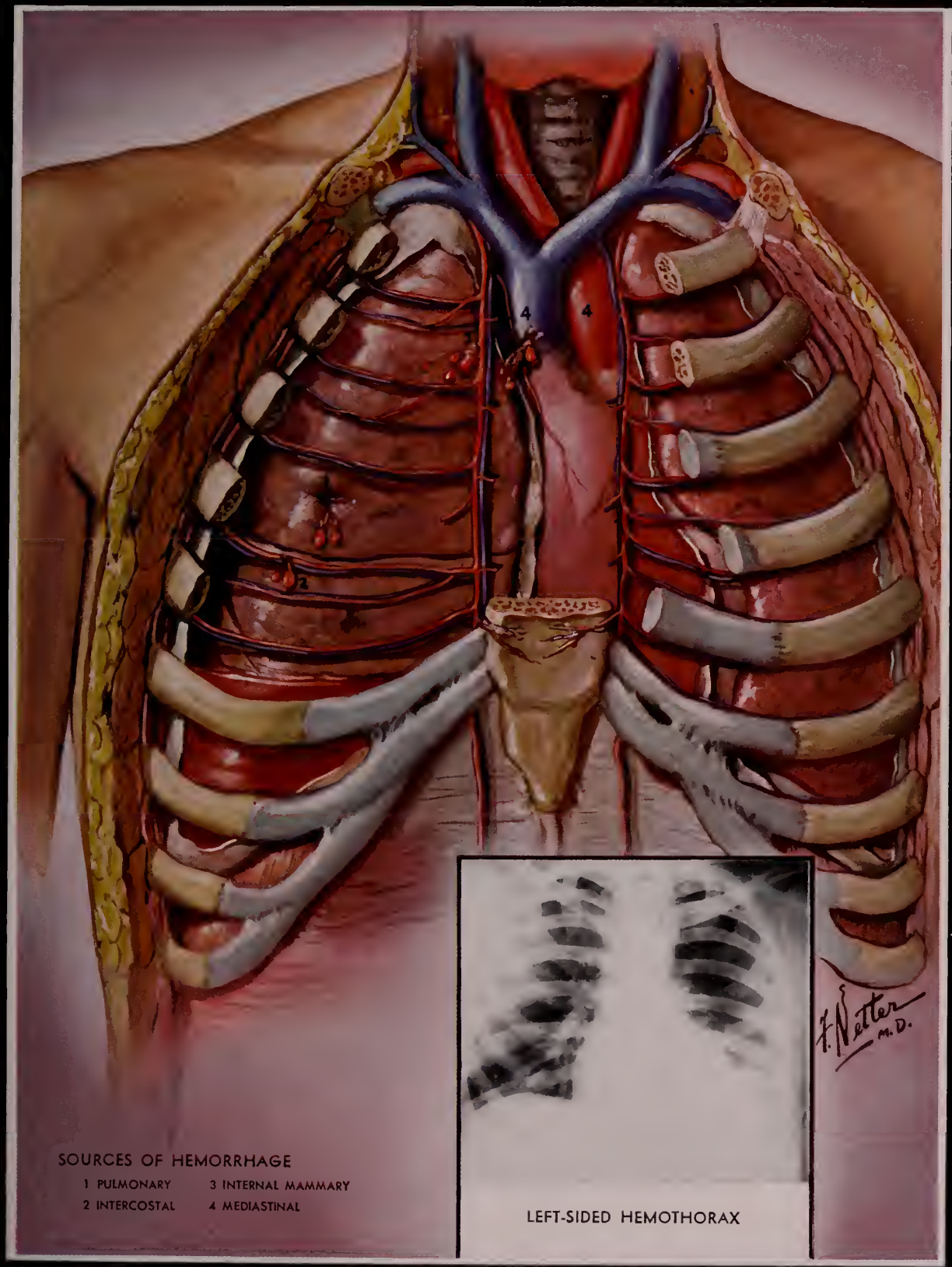
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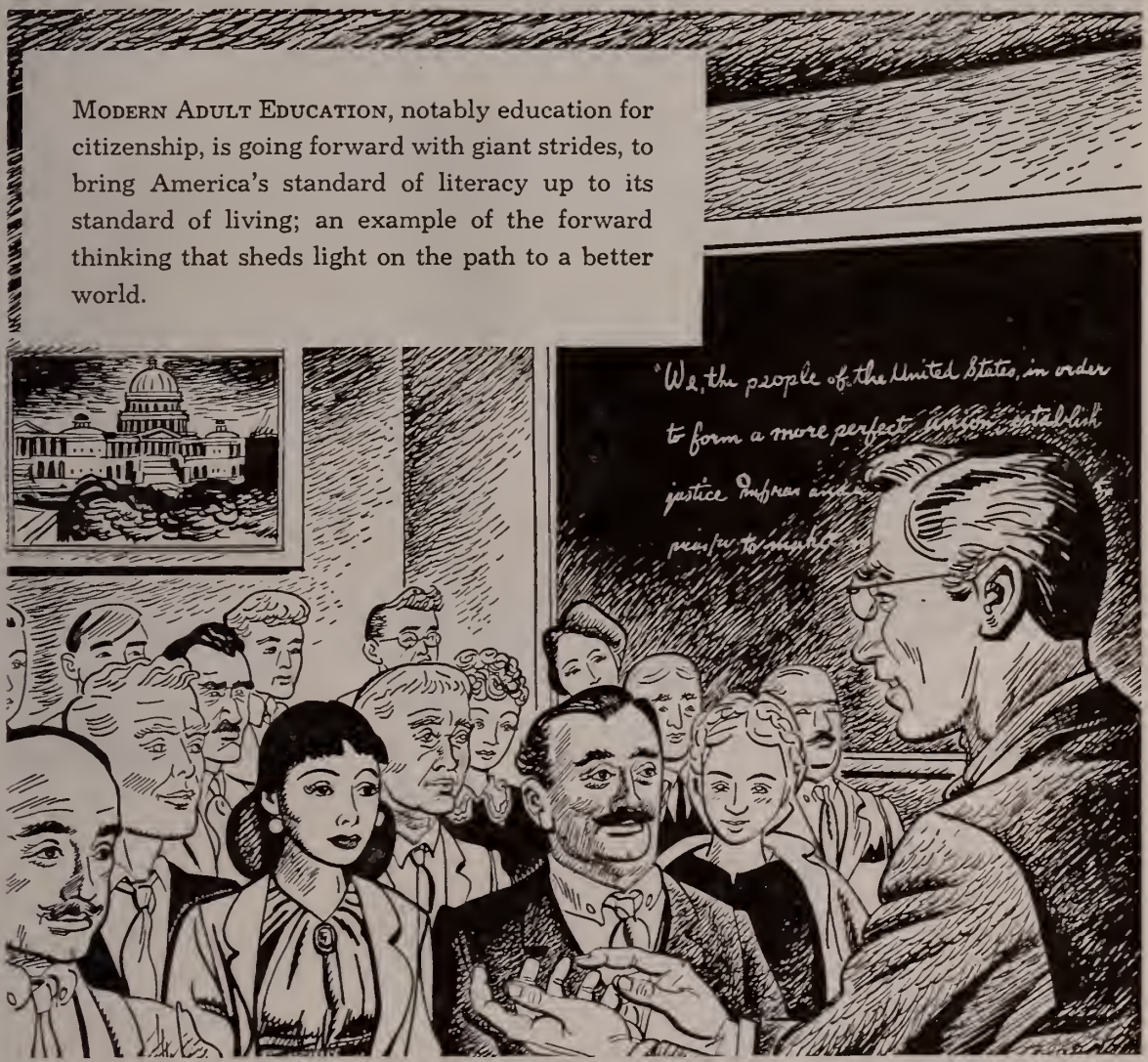
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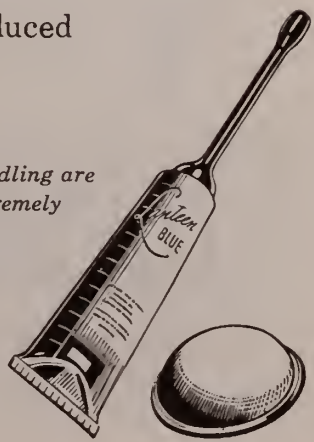
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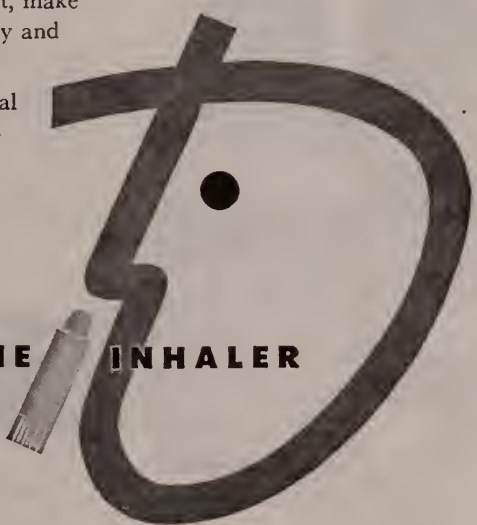
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Feinberg, S.M.: Allergy in Practice, The Year Book Publishers, Inc., Chicago, 1944, "Hay Fever Treatment."

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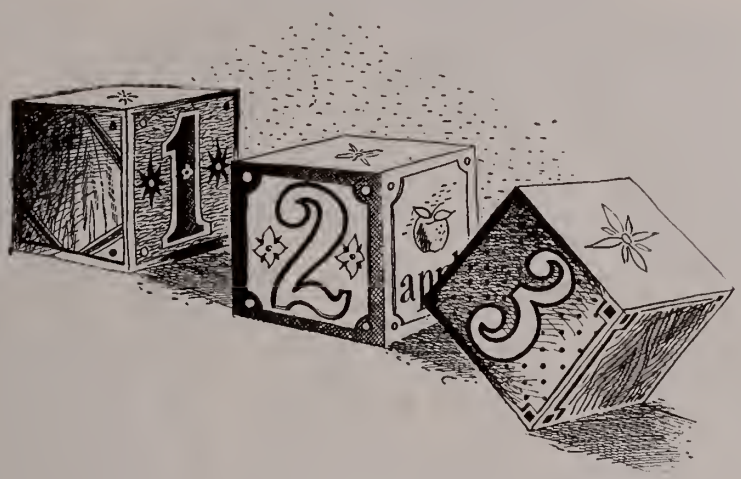
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1. Coburn, A. F.: Salicylate Therapy in Rheumatic Fever, Bull. Johns Hopkins Hosp. *73:* 435-464 (Dec.) 1943.
2. Smull, K., Wégria, R., and Leland, J.: The Effect of Sodium Bicarbonate on the Serum Salicylate Level, J.A.M.A. *125:* 1173 (Aug. 26) 1944.
3. New and Nonofficial Remedies, 1943, p. 57.

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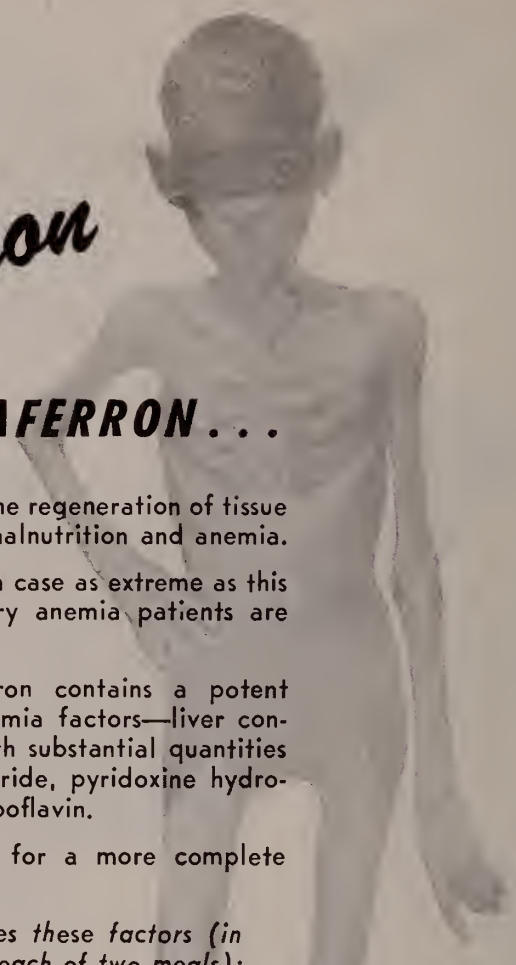
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The Illinois Medical Journal

Official Journal of the Illinois State Medical Society

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Editorials

WAY NOW CLEAR FOR PRE-PAYMENT MEDICAL CARE PLAN IN ILLINOIS

For more than one year, the Illinois State Medical Society has had a committee studying intensively all operating plans for medical care on a pre-payment basis. As the investigations continued, the necessity for the introduction of a suitable enabling act in the Illinois Legislature became apparent, and it was introduced early in June. The bill was passed by the Legislature and signed by the Governor on July 25, making the way clear to preceed with the proposed plans.

The Committee presented a report to the Council on July 29, and the following resolution was introduced and unanimously passed by the Council, which organization was given full power by the House of Delegates in 1944 to approve a plan for medical care on a pre-payment basis if it seemed desirable, and to place it in operation.

(1) RESOLVED that the Committee recommend to the Council the immediate adoption of an indemnity plan; that the Committee be empowered to make a further study with respect to the establishment of an indemnity plan or plans and to report its further findings to the Council.

(2) FURTHER that the Secretary be directed to notify the membership of the Society of the findings and recommendations of the Committee and of the action of the Council thereon; likewise notify the membership of the passage by the Illinois Legislature of the Enabling Legislation for Medical Service Plans Corporations, and its approval by the Governor.

The Committee proposes to recommend a definite plan for Council approval in the near future, and every component county medical society in Illinois will be informed as to further progress. Likewise a report of the action of the Council in approving the above resolution will be sent to the component societies at once so that the information will be received before this issue of the Journal is off the press. It seems quite probable that within a relatively short time some satisfactory prepayment plan for medical care of those in lower income groups will be in operation in this state.

NEW MEDICAL CARE PLAN FOR ALL THE PEOPLE

The American Medical Association through its Council on Medical Service and Public Relations and the Board of Trustees, presented in the Journal of the A.M.A. under date of July 21st, a constructive 14 point program for the extension of improved medical care for all people.

PREAMBLE

The physicians of the United States are interested in extending to all people in all communities the best possible medical care. The Constitution of the United States, the Bill of Rights and the "American Way of Life" are diametrically opposed to regimentation or any form of totalitarianism. According to available evidence in surveys, most of the American people are not interested in testing in the United States experiments in medical care which have already failed in regimented countries.

The physicians of the United States, through the American Medical Association, have stressed repeatedly the necessity for extending to all corners of this great country the availability of aids for diagnosis and treatment, so that dependency will be minimized and independence will be stimulated. American private enterprise has won and is winning the greatest war in the world's history. Private enterprise and initiative manifested through research may conquer cancer, arthritis and other as yet unconquered scourges of humankind. Science, as history well demonstrates, prospers best when free and unshackled.

PROGRAM

The physicians represented by the American Medical Association propose the following constructive program for the extension of improved health and medical care to all people:

1. Sustained production leading to better living conditions with improved housing, nutrition and sanitation which are fundamental to good health; we support progressive action toward achieving these objectives.

2. An extended program of disease prevention with the development or extension of organizations for public health service so that every part of our country will have such service, as rapidly as adequate personnel can be trained.

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3. Increased hospitalization insurance on a voluntary basis.

4. The development in or extension to all localities of voluntary sickness insurance plans and provision for the extension of these plans to the needy under the principles already established by the American Medical Association.

5. The provision of hospitalization and medical care to the indigent by local authorities under voluntary hospital and sickness insurance plans.

6. A survey of each state by qualified individuals and agencies to establish the need for additional medical care.

7. Federal aid to states where definite need is demonstrated, to be administered by the proper local agencies of the states involved with the help and advice of the medical profession.

8. Extension of information on these plans to all the people with recognition that such voluntary programs need not involve increased taxation.

9. A continuous survey of all voluntary plans for hospitalization and illness to determine their adequacy in meeting needs and maintaining continuous improvement in quality of medical service.

10. Discharge of physicians from the armed forces as rapidly as is consistent with the war effort in order to facilitate redistribution and relocation of physicians in areas needing physicians.

11. Increased availability of medical education to young men and women to provide a greater number of physicians for rural areas.

12. Postponement of consideration of revolutionary changes while 60,000 medical men are in the service voluntarily and while 12,000,000 men and women are in uniform to preserve the American democratic system of government.

13. Adoption of federal legislation to provide for adjustments in draft regulations which will permit students to prepare for and continue the study of medicine.

14. Study of postwar medical personnel requirements with special reference to the needs of the veterans' hospitals, the regular army, navy and United States public health service.

The American Medical Association, composed of the majority of physicians in this country, is desirous of developing plans to provide adequate medical care for all the people. They are interested in public health programs which include extensions in the field of preventive medicine. Plans for medical care on a voluntary prepayment basis are operating in many states today, and it seems desirable that these plans be enlarged and extended in the future.

Whether this is done through the development of medical service plans or cash indemnity plans is a matter for local decision. At any rate, to become most effective in the benefits to the American people, all plans for providing medical care should be under local supervision. It is quite obvious that no individual centrally operated plan for providing this care can be successful, as the needs vary in different states and communities.

The plans proposed by bureaucratic planners do not provide for medical care of the unemployed or the unemployable. This has been and will continue to be purely a local problem. It is possible for the basic political units to insure these people, their wards, under a prepayment medical care plan suited to the individual community. It is possible that certain communities may be unable to finance the desired type of prepayment medical care plan, and government subsidies may be indicated, but they should be administered entirely at the local level.

Proposal Number 12 in the program offered to the American people is worthy of much consideration. With more than 60,000 physicians with our armed forces and 12,000,000 or more men and women in uniform, it is certainly unfair to have any revolutionary change in the plan for providing medical care made without giving these people an opportunity to express their individual desires on the subject.

Many government officials have praised the medical personnel in the armed forces for the fine care which has been given to our men and women in uniform. The fine statistics have been stressed repeatedly as being so much better than ever before possible in warfare. These officers should be given every consideration when plans which would affect their future in civilian life are being considered by our Congress.

It is quite obvious that every state and county medical society should endorse heartily this new program, then be prepared to discuss it freely

with the legislators and others in civilian life who should be intensely interested in this — the doctors' plan.

PRESENT DAY TREATMENT OF VENEREAL DISEASES

Although apparently having no effect in the treatment of syphilis, the sulfonamides have aided materially in the treatment of gonorrheal infections in both male and female. For the past seven or eight years sulfonamides have played an important part in the treatment of this disease. The first members of the sulfa group of drugs used in gonorrhea therapy caused more toxic reactions than those used recently, and perhaps of all of these preparations sulfathiozole has been the remedy of choice.

More recently penicillin has been found to effect cures in shorter time and with fewer reactions. Investigations have shown that the sulfonamide drugs are strictly bacteriostatic and require the participation of antibodies and phagocytes to cure infections due to susceptible organisms.

Penicillin, however, has been shown to have a direct bactericidal effect and its results are not dependent on the development of specific immunity as is the case when sulfonamides are used.

Reports show the value of penicillin in the cure of gonorrhea in both sexes and with very little likelihood of the complications formerly seen in the female. Technique varies with individual investigators and apparently the exact treatment has not been definitely standardized.

An interesting article appeared in the June 9th issue of the Journal of the American Medical Association reporting the cure of 175 cases of gonorrhea with a single injection of penicillin. In this series of cases calcium penicillin was used with highly refined peanut oil and beeswax thoroughly blended and containing 150,000 Oxford units. Seventy-five cases were treated with this mixture and there were no failures. Penicillin dissolved in normal salt solution disappears from the blood at the end of four hours, while with the penicillin-peanut oil-beeswax preparation, penicillin was found in the blood for periods ranging from seven to ten hours.

An eight hour plan of treatment with penicillin was reported in the Lancet, March 24, 1945, in which 265 cases were treated with 99% cured. The penicillin was given in 30,000 unit doses dissolved in distilled water, given parenterally at two hour intervals for five doses, or a total of 150,000 units over the eight hour period. This report of 265 consecutive cases compiled by T. R. Lloyd Jones, F. G. Maitland and S. J. Allen of the British Navy, stated that a man could report in sick bay at 8:00 a.m., receive the treatment and return to duty cured at 4:00 p.m. the same day.

In recent literature the dosage of penicillin used in the cure of gonorrhea varies from 100,000 to 150,000 units. When less than this amount is used the percentage of cures is reduced accordingly. Although fewer cases of gonorrhea in women have been reported as having been treated with penicillin, the data now available shows that the treatment methods are quite similar to those used in the male, and with equally good results.

Penicillin has been used extensively in the treatment of syphillis, and again at this time the treatment has not been definitely standardized. It seems quite logical from recent reports that penicillin given intramuscularly or by the intravenous drip method using perhaps 200,000 units daily for a period of five or more days, will cause the complete disappearance of the spirochete pallidum, and frequently in sero-negative primary cases they will disappear within a period of 24 hours.

Herxheimer reactions do appear occasionally, perhaps within 8 to 12 hours after treatment is started, but reactions do not necessarily mean that the treatment must be discontinued. Various investigators have used a total of from 1 to 3 million units of penicillin in the treatment of syphilis with excellent results. Some encouraging reports have likewise been released showing a definite improvement in many cases of neurosyphilis treated with penicillin, although probably no definite conclusions should be reached relative to its real value at the present time.

In the case of gonorrhea, the patient should be kept under supervision for a period of at least three weeks. Frequent tests should be made for the presence of the gonococcus. While in the treatment of syphilis, the patient should be

watched closely with frequent serologic tests, over a period of perhaps two years.

Although much encouragement has resulted from the use of penicillin in the treatment of venereal diseases, the last word has not as yet been spoken, and the medical profession in general will be watching closely for additional reports on these subjects with the hope that definite conclusions may be reached in the near future.

EXERCISE, EMOTIONAL STRAIN PLAY PART IN HEART ATTACKS

Author Believes That In Acute Cases Early Diagnosis, Prompt Treatment Can Avoid 'Many Catastrophes'

Strenuous exercise and emotional strain can be definitely considered important contributory factors in attacks of coronary thrombosis, Lt. Col. H. L. Blumgart, Medical Corps, Army of the United States, points out in the July 14 issue of *The Journal of the American Medical Association.* He states that in Army experience, the occurrence of this heart condition during, or soon after, strenuous exercise "is striking."

In coronary thrombosis, which is two or three times as frequent in men as in women, a clot forms in one of the coronary arteries, or more frequently in one of its branches, and the portion of the heart muscle which is supplied by the stopped-up branch is deprived of arterial blood.

Medical authorities in the past have observed that coronary thrombosis very often occurs while the individual is at rest or asleep. Statistics show that there is an incidence of more than 50 per cent of these heart attacks during rest. One authority, analyzing 530 attacks, found that only two per cent followed unusual exertion, five per cent followed excitement and 37 per cent occurred during mild activity. He pointed out, however, that since half of the day of normal persons is spent in mild or moderate activity, one might well expect half of all attacks to occur during this period.

"Most military personnel," Colonel Blumgart states, "are called on to undertake strenuous effort and, particularly in the instance of some officers from civilian life, such effort is often decidedly unaccustomed. It therefore might be anticipated that if effort and myocardial infarction were causally related an increased number of such cases might be witnessed in the Army. This is indeed the case. The medical officers at practically every one of the many hospital installations which I have visited have witnessed one or more such instances."

Colonel Blumgart, who is on leave as associate professor of medicine at Harvard Medical School, cautions that physicians should make direct inquiry regarding all attendant circumstances prior to the onset of an attack.

"Much significant information not spontaneously volunteered by the patient frequently will be uncovered," he said, adding: "The appearance of distress on exertion or under emotional stress should indicate a tentative diagnosis of angina pectoris, of coronary failure or insufficiency . . . until such a diagnosis is clearly excluded on the basis of further evidence."

Colonel Blumgart believes that if undue strain is avoided by those suffering from a heart ailment and if, in cases of acute coronary thrombosis, the diagnosis is made early and appropriate treatment is instituted promptly, "many catastrophes doubtless can be avoided."

He warns further that "medical officers should maintain close supervision over all those assigned to their care when they undertake strenuous or prolonged activities."

GENERAL ELECTRIC X-RAY EXPANDS PLANT: MOVES OFFICES TO CHICAGO LOOP

In a move planned to increase plant capacity, President J. H. Clough announced today that the Main Offices of General Electric X-Ray Corporation will be transferred from the company's plant at 2012 Jackson Blvd., to a new location in the Insurance Exchange Bldg., 175 Jackson Blvd., Chicago.

In announcing the transfer, Mr. Clough said that it will make available an additional five-story building which will be used for manufacturing purposes. The company's plant consists of five buildings which occupy one city block at Damen Avenue and Jackson Blvd.

The move marks the sixth major expansion in the company's production facilities since its founding, as the Victor Electric Company, in a west-side basement workshop in 1895.

State Department of Public Health

SERVICES OF THE DIVISION OF INDUSTRIAL HYGIENE

The professional personnel of the Division of Industrial Hygiene of the State Department of Public Health consists at the present time of a physician, three engineers, two nurses, a dental consultant, and two chemists. It is operated as an impartial fact-finding, non-regulatory scientific agency with a philosophy of service and education rather than of law enforcement and regulation. Its services are available alike to industry, labor, the medical profession, the nursing profession and any citizen or group in the State of Illinois.

In the nine years of its existence, the Division has conducted surveys in over 6000 Illinois industrial establishments and has rendered diagnostic aid, advisory and other services to several hundred physicians. In addition, technical aid has been given to a large number of lay groups. At the present time the Division is heavily taxed with requests for service by industry and others directly concerned with problems of health due to the recognition of industrial hygiene as an aid to production and better employee-employer relations.

In rendering its services, a complete report is always submitted to the person or agency requesting the service. The thoroughness, completeness and character of these reports has received wide acceptance. Publicity is not given to any such surveys or services or to conditions encountered. The results of investigations and the remedies recommended are kept confidential.

The services of the Division, which are available at no cost, are briefly outlined below:

1. *Medical*

Evaluation of industrial envrionmental exposures.

Guidance in the development of industrial medical programs.

Diagnostic aid to physicians, hospitals, clinics and other medical institutions.

Maintenance of an Occupational Disease Clinic at the Research Hospital of the University of Illinois.

Morbidity and mortality studies of the industrial population.

Consultation and guidance to industry, labor, medical profession, local health agencies and other interested groups in matters of industrial hygiene.

General public health programs for promoting adult hygiene among industrial groups and communities.

Acting as a case-finding or disease-finding unit in industry for referral to other Divisions of the State Department of Public Health.

2. *Engineering*

Conducting plant surveys and individual studies of industrial workrooms, operations and processes.

Collection of industrial atmospheric contaminants and other hazardous materials for analysis and study.

Recommending methods for control of hazzards affecting health in industry.

Carrying out technical studies to determine efficiency of engineering control measures.

Selection and guidance in the use of personal protective equipment.

Preparing reports of findings and correlating work with medical services.

Assistance in the design of engineering control measures.

3. *Nursing*
 - Assistance in setting up nursing and first-aid programs.
 - Clearing house for industrial nursing information.
 - Development of public health programs among industrial nurses.
4. *Dental*
 - Dental surveys in plants to evaluate oral manifestations of occupational origin.
 - Assisting in the formulation and promotion of industrial dental programs.
 - Recommendations for improving industrial dental services.
5. *Chemical*
 - Analyses of samples obtained in the field and of materials submitted with reference to the causation of industrial disease.
 - Analyses of urine and blood submitted by physicians when special technics are required, for assistance in diagnosis.
 - Preparing apparatus for use in field studies.
 - Improving laboratory facilities for detailed analyses of industrial materials, air samples and other specimens.
 - Conducting research in methods of collection and determination of atmospheric contaminants.
 - Petrographic determinations.
 - Hematological studies.
6. *Education*
 - The Division of Industrial Hygiene acts as a clearing house for information on industrial hygiene. The Division maintains an extensive library.
 - Prepare for publication bulletins on various aspects of industrial hygiene.

Industrial disease, as in the case of any disease, has an etiology, pathology, and symptomatology. However, the diagnosis of an occupational disease rests upon a differential diagnosis. The anemia of benzol poisoning is the same clinically as a non-occupational anemia; likewise, the abdominal cramps of a lead colic are the same as those of acute appendicitis. Yet, these symptoms in the presence of an air sample indicating benzol, a urine-sulfate test, the use of lead or a stipple cell count are important diagnostic aids. These are the services which the Division of Industrial Hygiene can provide as diagnostic aids to the medical profession.

The engineering and chemical services of the Division are widely accepted by plant medical directors for appraising the environmental conditions of each job as to any occupational or hygienic risks involved. This information provides basic data for the development of the plant medical program and for the placement of personnel with regard to aptitudes, temperament, etc. In the event that a general practitioner provides the health services in an industry, such data are even more fundamental to successful experience.

Industrial hygiene falls within the province of two main professional groups, namely, medical and engineering. It is the physician's role to attack the physiologic factors of adverse working environment while the engineer confines himself to the physical factors. Both must work together for the successful solution of most of the problems. However, in most cases engineering services of this type are not available locally to the plant physician. In both these activities the physicians and engineers of the Division of Industrial Hygiene offer valuable service.

The nursing services of the Division can provide the physician with assistance in the planning of the industrial nursing services, and in adopting the newer procedures and activities in the field. The industrial dental services provide to the physician assistance in the development of a dental program designed to uncover sites of infection which may be an important factor in reducing the period of disability, in addition to the improvement of the general health, through improved oral hygiene. Added to these consulting dental services is the oral hygiene survey which includes mouth examinations to determine any oral manifestations of occupational origin due to such materials as acids, alkalies, dusts, mercury, lead and many other materials.

The foregoing services are direct activities of the Division of Industrial Hygiene. However, for the improvement of the general health of the workers, the Division of Industrial Hygiene is the channel through which all the activities of the Illinois State Department of Health may be brought to industry and the industrial physician. An example of this is the present tuberculosis case finding program developed with the Division of Tuberculosis Control. The use of the 35 mm photofluoroscopic mobile unit has had very wide acceptance by plant physicians for chest examinations of the entire personnel under their supervision.

In conclusion, the Division of Industrial Hygiene, through its special technics and procedures and the other activities of the State Department of Public Health, has available to the industrial physician, at no cost, many services which are designed to assist him in the diagnosis, treatment and prevention of disease in the working population, bringing to the plant a public health program in which the factory is utilized as the locus for a mass approach to the betterment of public health.

THE DIVISION OF COMMUNICABLE DISEASES

From the earliest days of recorded community activities, the control of communicable diseases has played a large part in the development of medical and public health services. The creation of most organized health departments can be traced to a demand on the part of citizens and the medical profession for the enforcement of measures designed to suppress and eradicate various contagious and infectious diseases. At one time, such measures consisted only of isolation and quarantine plus smallpox vaccination. However, as medical and laboratory sciences detected modes of the spread of disease and developed additional agents and techniques to achieve both passive and active immunity, public health organizations then became able to broaden their activities and to devote more time to the promotion of other aspects of healthful living. These developments, however, did not mean that the organized efforts against communicable diseases could be abandoned, for experience has demonstrated that the slightest relaxation of vigilance could easily result in the recrudescence of a communicable disease formerly well under control. Therefore, although not as dominant an activity of the health department as in previous years, the work of the Division continues much as it has in the past.

Communicable disease control measures were participated in by the State Board of Health since its creation in 1877, but the work was not centralized nor carried out in a systematic way until 1915 when the Bureau of Medical and Sanitary Inspection was established. Prior to that time, the field work was done by the Secretary of the Board of Health or physicians and lay quarantine officers employed on a per diem or part-time basis. In 1916 a State Epidemiologist and four full-time physicians each assigned to a district in the State were appointed.

In 1917 with the adoption of the Civil Administrative Code by the State Government and the establishment of a State Department of Public Health, the Bureau of Medical and Sanitary Inspection became the Division of Communicable Diseases, and has carried on its activities under that name since. With the decentralization of state health activities which began in 1940 and the establishment of local health services, many of the field activities formerly carried on by personnel of the Division have been transferred to local personnel with the Division exercising only technical supervision over their work. All reports, however, continue to clear through the Division office so that the legal responsibilities of the Department can be fulfilled.

The basic function of the Division of Communicable Diseases is to prevent and control communicable diseases. The work of the Division is divided into the following activities:

1. Morbidity Reporting.

All cases of communicable diseases, except venereal diseases and tuberculosis, occurring in the state are eventually reported to this Division where they are tabulated, analyzed, and summaries furnished to various agencies such as U. S. Public Health Service, the Army and Navy Medical Corps, other state health departments, and to district, county, and local health officers. Information obtained from these reports are of extreme importance for "no health department, state or local, can effectively prevent or control diseases without knowledge of when, where, and under what conditions cases are occurring." Before cases of communicable diseases can be reported, they must first be diagnosed and it is in this most important phase of the work of the Division that the cooperation of the medical profession is necessary. The correct diagnosis and a prompt reporting of the first few cases in a community can serve to check a threatened outbreak before it is well under way.

2. Isolation and Quarantine.

It is primarily through the Division of Communicable Diseases that the Department's rules and regulations for the proper control of communicable diseases are continuously revised and kept up-to-date as based upon the latest scientific knowledge available and designed to invoke the

least possible economic hardship. The statutes of the State give the Department supreme power of quarantine and the right to make rules and regulations for the control of communicable diseases. They also confer the responsibility of seeing that such rules and regulations relative to isolation and quarantine are properly carried out.

3. Local Health Officers.

The Division provides assistance to local health officials in carrying out their legally prescribed duties of enforcing the rules and regulations of the Department.

4. Epidemiological Investigations.

Cases, outbreaks, and epidemics of various communicable diseases are investigated to ascertain sources of infection and to institute proper control measures to prevent spread.

5. Immunization.

An important phase of the Division's work is the study and development of means of prevention of communicable diseases and the encouragement of the use of such agents.

6. Biologics and Drugs.

The Division furnishes and distributes without charge biologics and drugs for the prevention and treatment of certain communicable diseases. In every county of the State, there is at least one official agency for the distribution of State-supplied biologics and these materials can also be obtained by physicians directly from the Division or from district, county, and city health departments. At the present time the following preparations are distributed by the Division: Dick and Schick tests, diphtheria antitoxin, diphtheria toxoid, rabies vaccine, scarlet fever toxin, silver nitrate solution, smallpox vaccine, tetanus antitoxin, typhoid vaccine, whooping cough vaccine, botulism antitoxin, immune serum globulin, sulfathiazole, sulfadiazine, and poliomyelitis convalescent serum.

7. Consultation.

Consultation service is provided to the physicians of the State in the diagnosis and treatment of communicable diseases. Requests for such service may be made through the district or county health department or directly to the Division office.

FIND PENICILLIN AN IMPORTANT AGENT IN TREATING GAS GANGRENE

Penicillin has become an important agent in the treatment of gas gangrene — one of the bacterial horrors of war — according to a study reported in the July 14 issue of *The Journal of the American Medical Association.* Lt. Col. Francis H. Langley and Capt. Lawrence B. Winkelstein, Medical Corps, Army of the United States, are the authors of a paper in which they report on 96 cases treated in an Army evacuation hospital.

Gas gangrene is a local wound infection caused by bacteria which attack only injured tissues, form spores and secrete powerful toxins. The authors state that "the disease develops so soon after wounding and runs so swift a course that delays and difficulties of treatment in the field are not the principal reason for its high incidence and mortality."

The Army doctors emphasize that early surgical débridement — removal of the damaged tissue — "is the one single measure of vital importance in the prophylaxis as well as the treatment of gas gangrene."

Surgery alone, however, is not completely effective in treating the infection. Penicillin in large doses has helped to reduce both mortality and extent of the disease. Gas gangrene antitoxin also plays an important role, for while penicillin may definitely stop the growth of the organisms, the neutralizing effect of the antitoxin is essential for the cure of the disease.

After completion of the surgery, therefore, the physicians sum up the specific treatment of gas gangrene infection as "the active and aggressive use of penicillin and gas gangrene antitoxin, the former for its action against the organisms themselves and the latter for overcoming the toxins produced by them."

Correspondence

WOMAN'S AUXILIARY 1945-1946

Due to the fact that it was impossible for the Woman's Auxiliary to the Illinois State Medical Society to hold a meeting of the House of Delegates, most officers and chairmen will continue serving on the Board.

President Mrs. Alfred F. Gareiss
President-Elect Mrs. E. W. Burroughs
First Vice-President ..Mrs. Arthur I. Edison
Second Vice-President Mrs. E. F. Dietrich
Third Vice-President Mrs. C. W. Stuart
Treasurer Mrs. E. G. Beatty
Recording Secretary Mrs. D. E. Meier
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.....Mrs. Theodore Johnston
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Ninth District Mrs. W. E. Stanelle
Tenth District Mrs. C. C. Kane
Eleventh District Mrs. D. W. Killinger

Chairmen of Standing Committees

Archives Mrs. W. C. Bornmeier
Benevolence Mrs. E. M. Egan
Bulletin Mrs. R. E. Johnson
Convention Mrs. William Murray
Credentials and Registration
.....Mrs. P. P. Youngberg
Finance Mrs. H. W. Miller
Hygeia Mrs. C. W. Stuart
Legislation Mrs. Roy M. Hutchison
Organization Mrs. E. W. Burroughs
Public Relations Mrs. E. F. Dietrich
Press and Publicity Mrs. F. M. Hagans
Printing Mrs. Carl E. Sibilsky
Program Mrs. Arthur I. Edison
Revisions Mrs. G. Henry Mundt
War Service Mrs. S. G. Plice
Parliamentarian Mrs. Clarence Goodwin
Hostess Mrs. W. J. Wanninger

CANCER INFORMATION BUREAU OPENED IN CHICAGO

The Chicago Cancer Committee announces the opening of a Cancer Information Bureau at 139 North Clark Street, where facts concerning cancer control and information about facilities for the diagnosis and treatment of cancer will be made available to the public. The Bureau is being established in cooperation with the Field Army of the American Cancer Society.

Dr. George E. Wakerlin is chairman of the Chicago Cancer Committee which was organized in 1941, under the leadership of Dr. Ludvig Hektoen, to co-ordinate the activities of all groups engaged in cancer control work in the Chicago area, to encourage research and education of the public, and to assist in the establishment of diagnostic and treatment facilities. Dr. Hamilton R. Fishback is chairman of the committee for the Information Bureau.

In announcing the opening of the Cancer Information Bureau, Dr. Wakerlin stated that since most cancer is curable in its early stages, education of the lay public is the most effective of all the weapons available today in the fight

against this disease. No diagnostic or treatment activities will be carried on by the Bureau; its function, Dr. Wakerlin said, is educational — to guide those having suspicious symptoms to doctors or clinics while there is yet time to save them from death.

BEG YOUR PARDON

To the Editor: —

There appeared in the July, 1944, issue of the Illinois Medical Journal, in the News of the State, under Deaths, page 79, the following notice:

"Alexander W. Burke, Chicago; University of Illinois, College of Medicine, 1909. Flight Surgeon at the Airport. Was Captain in World War I. Died following a heart attack in Memphis, Tennessee, June 4, 1944. Age 55."

Please be advised that I graduated from the University of Illinois, College of Medicine, in 1909, and there was no other person by the same name who graduated from there in 1909.

Dr. Alexander Walter Burke, who died in Memphis, Tennessee, June 4, 1944, graduated from Loyola University, School of Medicine, in 1916.

I should be grateful if you would publish this correction in the next issue of the Illinois Medical Journal.

Thank you for your very kind attention to this matter.

Very truly yours,
Alexander William Burke, M.D.
District Health Superintendent,
36½ Locust Street,
Pana, Illinois.

NEW OFFICERS FOR ILLINOIS PSYCHIATRIC SOCIETY

At the Annual Meeting of the Illinois Psychiatric Society held on May 5, 1945, the following officers were elected for the year 1945-46:

Dr. John J. Madden, President
Dr. Frances Hannett, Vice-President
Dr. Charlotte G. Babcock, Secretary-Treasurer
Dr. David Slight, Councilor
Dr. Edward P. Ross, Councilor

ALLERGY SOCIETY HAS ELECTION

The following officers have been elected for the Chicago Society of Allergy:

John Peters, Oak Park, Ill. Pres.
Wm. A. Mowry, Madison, Wis. Pres.-Elect
Edw. Geo. Tatge, Evanston, Ill. ..Sec'y., Treas.

SINGING NOT ADVISED FOR PERSONS WITH ARRESTED TUBERCULOSIS

Is singing advisable for a person who has a moderately advanced case of tuberculosis? The answer is definitely no!

In reply to this query, the July issue of *Hygeia, The Health Magazine,* advises against the extra strain that professional singing may put upon the lungs with healed lesions. Because rest is so important for the sick lung, the treatment of pulmonary tuberculosis usually involves pneumothorax — in which the lung is artificially collapsed and immobilized for healing. Possible reactivation by overloading already weakened lungs with an extra amount of work and strain would be tempting fate.

"The plea that many people with weak lungs study singing with the object of strengthening their lungs hardly applies here," the *Hygeia* article says. "Many of these people presumably had healthy lungs to begin with and have no trouble. On the other hand, if there is some weak spot in the lungs, the singing might possibly be the last straw."

Any opportunity which presents itself for the physical examination of any worker should be considered an opportunity to find tuberculosis and to exert every possible effort against its spread. T. Lyle Hazlett, M.D., Indust. Med., Mar., 1944.

Medicine's Role in the War Effort

THE SUPPLY OF MEDICAL STUDENTS AND PHYSICIANS

Memorandum presented on June 4, 1945 to President Harry S. Truman by a special committee of the Committee on Post-war Medical Service consisting of Evarts Graham, M.D., St. Louis; Victor Johnson, M.D., Chicago; Harvey Stone, M.D., Baltimore, and Fred C. Zapffe, M.D., Chicago.

Whatever measures may be taken in the near future for the improvement of the health of this nation, including the construction of additional hospital facilities and the extension of various plans of prepayment insurance against sickness, it would seem to be axiomatic that physicians must be provided in adequate numbers if these measures are to succeed. Yet we are now failing to provide for the training of enough physicians to meet the demands for doctors which we know will increase after the war.

At that time we shall need about 30,000 more physicians than before the war, primarily because of the requirements of the Veterans Administration (about 15,000) but also because of the needs of the peacetime Navy (about 5,000) and the Army plus possibly a compulsory universal military training program (about 10,000). This estimate disregards extra physicians required to provide replacements for casualties among medical officers, medical assistance to liberated countries and the more complete and extensive medical care demanded in this country.

Even if admissions, enrolments and graduations from our medical schools should continue at the present wartime levels, only about half of this need would be met, since 40,000 students will receive the M.D. degree in the period 1942 to 1948 and 24,000 physicians will have died during that time. Thus, under the most favorable conditions only about 16,000 additional physicians will be available after the war to do the work of 30,000.

In spite of this, freshman enrolments in the medical schools of this country will be drastically reduced within the next year. In the past year virtually no able bodied males have been permitted to commence the two year course of college premedical studies because the Army and Navy have ceased assigning men to such studies and the Selective Service System has discontinued deferments of premedical students. In the past few years each freshman class of about 6,000 students included 4,000 to 5,000 able bodied men. These are no longer available under existing regulations.

From now until some time after the war, medical schools must enroll their freshman from the following limited groups: women, physically disqualified males, men under or over the draft age and veterans. Relatively small numbers are available in these categories: medical schools annually receive applications from only 800 to 900 women and even fewer physically disqualified males; men under 18 or over the draft age can be disregarded, since there is only a handful of such students enrolled in medical studies. These three categories would scarcely supply 1,200 to 1,500 entering freshmen for the medical school classes of early 1946, even if all who applied to medical schools were admitted, with complete disregard for the qualifications of the applicants for the study and practice of medicine.

Major Gen. Lewis B. Hershey, the director of the Selective Service System, has stated that several hundred, or even a few thousand, acceptable medical applicants should surely be forthcoming from the hundreds of thousands of veterans being discharged from the armed forces. Checking on this statement indicates that it is a belief without foundation in fact. Eight large universities (California, Chicago, Illinois, Iowa, Michigan, Minnesota, Northwestern and Wisconsin), which normally supply 800 to 900 of the entering freshmen in our medical schools, now have enrolled just 42 veterans in premedical studies who will complete their preparation for entrance into medical school before 1947. Only 28 of these were considered probably acceptable as medical students and physicians. Generalizing from these data, it would seem that veterans may be expected to provide less than 4 per cent of the freshman class before 1947, totaling perhaps 200 to 300 students as compared with the total of 6,000 normally admitted.

Within the next year medical school freshmen admissions will be reduced by about 5,000 because of the existing policies and there will be an equal reduction

in M.D. graduates three years hence. To write off 5,000 physicians is equivalent to depriving medical care from 100,000 hospitalized veterans, 1,000,000 soldiers or sailors or 4,000,000 civilians. Passage of even the best of the scores of medical care and hospitalization bills now pending in Congress and state legislatures would be ineffective and meaningless if we simultaneously prohibit the training of sufficient doctors.

This deficiency can be corrected under the present Selective Service Act as follows: Defer qualified men now in college premedical studies when they reach 18 and defer 8,000 selected high school graduates of this year to commence college studies in premedicine. From these 4,500 should be earmarked for admission to specific medical schools a year later. Repetition of this procedure each year the war lasts would effect the training of enough doctors to care for the health of the people. Consideration might also be given to the assignment of a limited number of men now under arms back to premedical studies, provided they pursue such studies satisfactorily before induction, as far as this may be consistent with military necessity.

It is of basic importance to note that the restrictive regulations now in effect were promulgated a year ago. Since that time the war situation has radically changed. Even though we still have a tremendous task ahead, requiring the mobilization of all necessary resources, it remains true that the Selective Service System has recently announced a reduction in the rate of induction of men into the armed forces by 30,000 per month starting in July. It is not apparent that the deferment of a small percentage of this number of premedical students would in any way affect the military situation. On the other hand, it would help to insure adequate medical care of civilians, including veterans, after the war.

The acute need for an appropriate adjustment is underscored by the realization that the present policies will result in the same drastic reduction in medical school enrolments for each year that the Asiatic war lasts. It will even continue for a period after the peace, since premedical studies require two years before a student is ready to enter a medical school. The necessity for a continuous flow of students into and through our medical schools has been urged by the Surgeons General of the three armed services, by Mr. Paul McNutt of the War Manpower Commission, by Dr. Frank Lahey, chairman of the Directing Board of the Procurement and Assignment Service for Physicians, by every medical school in the country with a single exception and by virtually all medical educators and leaders in the medical profession. This conviction does not represent a special interest or problem of the medical profession or the medical schools. Actually, most medical schools would welcome an enforced period of relaxation from their arduous wartime program involving increased enrolments and acceleration of the training. The proposed adjustments are dictated only by the necessity for preserving the health of the nation.

DR. WILLARD O. THOMPSON AWARDED CERTIFICATE OF DISTINGUISHED SERVICE

Dr. Willard O. Thompson, chairman of Regional Committee No. 14 of the Committee for Wartime Graduate Medical Meetings, was recently awarded a Certificate of Distinguished Service by Major Gen. Russell B. Reynolds, commanding general, Sixth Service Command. According to the citation accompanying the award, "In 1942 the American Medical Association, in conjunction with the American College of Surgeons and the American College of Physicians, established a fund to provide postgraduate medical instruction for medical officers stationed throughout the Army. Dr. Willard O. Thompson, chairman of the Committee for Wartime Graduate Medical Meetings for Region No. 14, which includes Illinois and Wisconsin, obtained the services of prominent teachers and practitioners of medicine to lecture and conduct clinical exercises in the hospitals of the Sixth Service Command. He himself has actively participated in the teaching, and by boundless energy and enthusiasm has maintained the continuity and high quality of the program. The medical officers of this service command as well as hundreds of civilian physicians who have attended the courses at army hospitals have universally expressed their appreciation for this unusual opportunity for postgraduate instruction, which has definitely raised the standard of medical practice in the Sixth Service Command. Dr. Thompson, as chairman of the committee, by his untiring efforts and devotion to this important program, has rendered distinguished service to the Sixth Service Command, and in recognition thereof the commanding general is pleased to present this citation."

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HOW WHOLE BLOOD IS SHIPPED TO THE PACIFIC BY AIR

Whole blood is shipped successfully across the Pacific by air in an insulated container in which the bottled blood is placed in racks around a large compartment of cracked ice, according to Charles F. Belshaw, research consultant of the National Association of Ice Industries. He explained that although temperatures inside planes in the Pacific often go as high as 130° F., this method keeps the blood to be used in treating the wounded at a temperature between 40 and 45° F., which is necessary to keep it in usable condition. He also revealed that vegetable produce shipped bedded down in finely granulated ice keeps its freshness, crispness and vitamin C content over a longer period. This was learned from research conducted in twenty-one colleges. "This method of refrigerating produce with snow-ice is like the protective effect of the late spring snows on vegetation," Mr. Belshaw said. The research further showed that vitamin C retention in foods is essential in maintaining flavor and that keeping vegetables fresh through the use of snow-ice will bring food to the dinner table so that it tastes better and is better nutritionally.

COLONEL LUETH, CHIEF OF CLASSIFICATION BRANCH

Lieutenant Colonel Harold C. Lueth of Evanston, Ill., has been assigned as Chief of the Classification Branch, Military Personnel Division, Office of The Surgeon General.

Before coming to the Office of The Surgeon General in February of this year, Colonel Lueth was Liaison Officer for The Surgeon General to the American Medical Association, with headquarters in Chicago — a post which he held for three years. He also served as Consultant in Procurement and Assignment to the War Manpower Commission.

Colonel Lueth entered on active duty in 1940, serving as medical instructor in the Illinois Military Area and later as Chief of Medical Service at Fort Sheridan, Ill. He received his medical degree from Northwestern University in 1930.

★ ★

"SULFA" IN WOUNDS DISCONTINUED

The Army's accumulated experience in wound management does not justify the local use of any chemical agent in a wound as an anti-bacterial agent, according to the Office of The Surgeon General. The local use of crystaline sulfonamides (sulfa powder) has therefore been discontinued except in the case of serous cavities where its use, while permissible under the direction of the surgeon, is not recommended. This subject is covered by War Department Circular No. 160 as amended by W. D. Circular No. 176, 1945.

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NEW APPOINTMENT

Lieut. Col. Fred E. Ball, formerly of Chicago, has been appointed District Consultant for Internal Medicine to the Air Surgeon. Now chief of Medical Services at the AAF Regional and Convalescent Hospital, Miami District, Colonel Ball is consultant for the Southeast District, which comprises the states of Tennessee, Mississippi, Alabama, South Carolina, Georgia and Florida. Dr. Ball graduated from the University of Minnesota Medical School, Minneapolis, in 1923 and entered the service in 1942.

★ ★

AMPLE PENICILLIN IS REPORTED AVAILABLE SINCE W.P.B. RELEASE

Some communities report that ample supplies of penicillin are now available for those needing it, since the War Production Board released approximately 885,000,000,000 units for civilian distribution after March 15.

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MEDICAL NUTRITION LABORATORY

The formal opening and dedication of the Army Service Forces Medical Nutritional Laboratory, Surgeon General's Office, U. S. Army, took place June 9 at the Chicago Quartermaster Depot. Major George H. Berryman, commanding officer of the Medical Nutrition Laboratory, presided.

PUBLIC HEALTH SERVICE PERSONNEL GET MILITARY STATUS

President Truman has by executive order given 3,000 U. S. Public Health Service members military status for the duration of the war. This action was taken under authority of the Public Health Service Act of 1944 and is effective July 21. The Public Health Service has no enlisted personnel, and its commissioned corps of around 3,000 includes physicians, dentists, sanitary engineers, pharmacists and other scientists and nurses. The President's order gives this personnel the same status, benefits, discipline and obligations of members of military establishments and provides uniformity in status and in discipline as between various members of the U. S. Public Health Service commissioned corps. Formerly some officers acquired veteran status while others did not, depending on their assignments. The order does not transfer administration of the Public Health Service either to the Army or to the Navy.

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NAVAL MEDICAL CHIEF LAUDS CARE OF WOUNDED ON OKINAWA

Vice Admiral Ross T. McIntire informed civilian and service personnel of the Navy Bureau of Medicine and Surgery that navy medical men caring for troops wounded on Okinawa "have lacked nothing" in supplies and equipment. His comment was made during presentation of awards to personnel for beneficial suggestions and achievement.

★ ★

NAVY INTERN TRAINING OUTLINED IN NEW BOOKLET

A booklet entitled "Essentials of Internship and Residency-Type Training in United States Naval Hospitals" (Navmed 762) has been prepared by the Professional Division, Bureau of Medicine and Surgery, and is now available for general distribution. This outline was initiated by the Honorary Consultants to the Surgeon General of the Navy. It describes the educational standards and program including uniform hospital libraries necessary to maintain official approval for internship training and for residency-type training in the specialties.

Its foreword by Vice Admiral Ross T. McIntire, Surgeon General of the Navy, states that "junior medical officers assigned to specialty services in naval hospitals will not be termed residents, nor will such services be designated formally as residencies. However, as far as the educational program for such services and assignments conforms with approved residency-type training standards, residency credits will be obtainable by junior medical officers for time engaged in such work while in naval service."

It is possible also for many medical officers assigned to larger dispensaries and other activities to obtain similar residency credits before the American colleges and the American boards.

Original Articles

HOSPITAL CARE FOR THE PATIENT WITH ACUTE POLIOMYELITIS

Mary S. Sherman, M.D.
CHICAGO

In every epidemic of poliomyelitis the tendency is either to over-emphasize the currently popular "specific therapy," or to concentrate on the ultimate manifestations of paralysis. This is unfortunate, both because it leads to the erroneous assumption that only specially trained personnel can treat acute poliomyelitis successfully and even more because it diverts attention from the fact that the major problem is one of medical and nursing care for the acutely ill patient.

The purpose of this paper is to show that good treatment can be carried out adequately in a general hospital and to outline the basic principles of such treatment.

In most localities there is a strict quarantine for poliomyelitis which, together with the ill-advised publicity which has been widely released in the last few years, has created an unwarranted fear of the disease. Actually poliomyelitis has a relatively low attack rate and is much less contagious than most of the common infectious diseases of childhood. There are few authenticated cases of poliomyclitis contracted from patients by those attending them, and cross-infection in hospitals is extremely rare. Poliomyelitis cases can therefore properly be admitted to a general hospital not specifically dedicated to contagious diseases.

If this is done the first requisite is a proper examining room where suspects may be seen. During an epidemic many patients are suspects and the admitting officer will be confronted by everything from lobar pneumonia to post-convulsive paralyses and hysteria. Consequently he must have at hand facilities for a complete physical examination. If the patient has bulbar paralysis, which is usually obvious, no time is lost in examination but he is admitted forthwith. If, after examination, there is a question of poliomyelitis, a spinal tap is done at once. When this is diagnostic, the patient can be admitted directly to the isolation ward; when it is negative or doubtful he can be admitted to another part of the hospital or sent home under close supervision. This arrangement obviates the necessity of having these patients expose many others or of their being admitted to the contagious ward before the diagnosis is established.

It is impossible in the first 3 or 4 days of the disease to predict the course a given patient will follow. It is true that some 80% of them will recover without significant residual paralysis,[1] but there is as yet no means of telling which early cases will be among the 80%. Furthermore, by the time the disease is unquestionably serious, mere transportation to the hospital may be harmful. Especially is this true with regard to those patients who after the first 24 to 36 hours develop frank bulbar involvement. It is therefore wise to admit all acutely ill patients as soon as the diagnosis is established. Early convalescent patients present a different problem and need be admitted only when some factor in the individual case makes hospitalization advisable.

Because of the peculiar nature of poliomyelitis and the fact that physical exertion, while it has not been proven harmful, may be a factor in the

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ultimate outcome, patients should be brought to the hospital in ambulances or in cars large enough so that they need not sit up. While this will in many cases prove unnecessary expense, it is insurance for those patients who might be harmed by any extra effort.

Once the patient is admitted to the hospital treatment is determined by the type and severity of the disease.

Suspects: In this group are those whose condition suggests poliomyelitis but who present insufficient findings for a conclusive diagnosis. Other febrile diseases have been ruled out by history and physical examination, and there remain a few patients who have fever, upper respiratory symptoms, headache, etc., but who have normal spinal fluid findings. For them only bed rest and observation are indicated. Few such suspects develop poliomyelitis but there have been some who, with no more preliminary than this, went on to frank paralysis. Also, the number of patients who have clinical poliomyelitis but who have normal spinal fluid findings may be as high as 12.5%.[2]

Nonparalytic And Preparalytic Patients: In the average epidemic one may expect 20-55% abortive or nonparalytic cases. (Wickman 25-56%;[3] Hamilton 41.6%;[4] Ogilvey 49%[5]). These are the patients who never show any detectable weakness and they make a completely uneventful recovery under any therapy. Of the 3 authors cited, Wickman wrote before "specific" measures were advocated, Ogilvey worked during the serum period, and Hamilton used the so-called "modern orthodox" method. Stuck, using Kenny packs, noted 25 nonparalytics in 87 cases, or 28.7%.[6]

Most of these patients are acutely ill, dehydrated, and toxic. Aside from the close observation made necessary because any of them can in the first few days suddenly show paralytic or bulbar signs, their care is that of any acute febrile illness. Although many physicians advise special diets and high vitamin intake, these measures have not proved to be of any assistance. The frequent emphasis on purges and enemas seems not only unnecessary but dangerous inasmuch as it interferes with rest.

In general these patients need absolute bed rest, as nearly normal a diet as possible, and adequate fluids, administered parenterally if necessary. They are disturbed only for frequent rapid physical examinations so that any change may be detected immediately.

As a rule the acutely toxic stage is over in 3 or 4 days, the temperature falls, the neck and back rigidity and the muscle pains begin to subside, and the patient is convalescent. At this time he may be discharged from the hospital for home care.

Paralytic Patients: The remaining patients will have spinal or bulbar involvement or a combination of the two. Of those who have spinal paralysis 12-44% may be expected to make a complete recovery[7,9] and only 10-20% of the total number of cases will have significant residual weakness[8,9]. These figures vary widely with the epidemic.

Paralytic patients in the acute stage are given essentially the same care as the nonparalytic. No special apparatus is necessary unless the patient's comfort demands it. If, for example, a paralyzed limb persistently falls into an uncomfortable position, some support is needed, and it makes no difference whether this is provided by posture, pillows, sand bags, or casts. If the patient has considerable pain he is given mild sedatives which relieve both pain and "spasm" remarkably well. The paralytic patient also receives frequent muscle examinations as it is impossible without them to tell how much involvement he has and whether it is increasing or decreasing. No one has shown that the slightest harm results from this practice even when it is repeated several times daily. In this fashion it is possible to detect early the signs of intercostal involvement which is the most feared development and which may require emergency treatment.

Bulbar And Encephalitic Types: The percentage and severity of bulbar involvement varies greatly. Occasionally there is a high incidence of mild cases as in Manitoba in 1941 when 15% of the patients had palatal involvement but there was a total death rate of only 1.8%.[8] In a series of 70 cases there were 18 with bulbar involvement (26%) which is an unusually high incidence but corresponded with that of the 1943 Chicago epidemic.[9]

In general the death rate of bulbar poliomyelitis is high. Levinson estimates it at between 60-80%.[10] However it is in this group that prompt and well-sustained care in a hospital can

be life-saving. The diagnosis can usually be made from a brief history and superficial observation. If so, nothing further is done for diagnostic purposes and even spinal fluid examination is postponed. The least disturbance is contraindicated as activity may sometimes precipitate an otherwise avoidable fatality. Oxygen is begun by nasal catheter if there is the slightest anoxia, and the patient watched 24 hours a day for signs of difficulty in swallowing. When these develop there is concomitantly an accumulation in the patient's throat of secretions of which he cannot rid himself. Constant suction by means of a nasal catheter attached to a water pump is instituted, nothing is given by mouth, and adequate fluids are given by parenteral routes.

During the few days that swallowing and coughing are impossible it is better to forget about trying to feed the patient. He will not suffer as long as his fluid balance is maintained. It is a wise precaution to employ a Wangensteen apparatus in order to keep the stomach empty and thus to minimize the possible damaging effects due to constant regurgitation of acid gastric juice through a relaxed cardia. If this is done special attention must be paid to replacing the chloride loss.

If all goes well 3 or 4 days of the above regime will see the bulbar patient through the most critical period. As soon as he can swallow at all he is fed (by an attendant who supports the patient's head), small quantities of some soft strained food which contains no particles too large to go through the suction tube. The suction is left on at first. When some of the food is actually being swallowed, the attendant can pinch off the suction tube intermittently. If there is still no trouble, liquids may be tried very cautiously. Finally the suction catheter may be removed although a bedside suction apparatus must remain instantly available. Under no circumstances should the patient try to feed himself until swallowing is practically normal.

If involvement advances there must be someone in constant attendance. The most important single principles are the prevention of aspiration and the maintenance of an adequate airway. For patients who have a palatal and pharyngeal paralysis it is advantageous to insert a tracheal catheter to guarantee the airway and to afford a passage for the suction catheter. Oxygen can be administered either through another catheter or with a mask. When plugging of a bronchus occurs, or when the entire respiratory tract becomes partially blocked with secretions, these measures will be insufficient and bronchoscopy may be necessary. This is a serious procedure and not without danger in an already panic-stricken and exhausted patient, but it may be a life-saving measure.

These precautions will usually maintain a completely patent respiratory tract. Tracheotomy is rarely if ever indicated. This operation makes accessible to the suction catheter only a very small additional area of the trachea and it does not suffice for a patient with lower respiratory tract obstruction.

These patients often have complications which must be treated individually and which not infrequently become more dangerous than the original disease. This is true particularly of those patients who develop atelectasis or pneumonia as the bulbar signs are subsiding. Most of these cases will end fatally, but with constant vigilance and effort a few will be saved. That this general regime is of value is attested by the low mortality (4 of 18 cases) in the series thus treated.[9]

As is explained subsequently in more detail, the respirator is not used in the management of the purely bulbar patient.

"Specific" Measures: 1. *Serum.* The use of serum is generally determined by the personal preference of the physician, the demand on the part of the family, and the availability of the material. Many reports have indicated that there is probably no specific value in its administration[11, 12, 13] but since it is excellent supportive therapy for an acutely ill patient who cannot eat, there is no objection to its use.

There are still those who debate the route of administration of serum. Since the intrathecal administration necessarily introduces a hypertonic protein solution into the spinal canal, and since its introduction is often followed by a severe reaction, it seems reasonable to give all serum intravenously.

2. *Packs.* It has been asserted in recent years that hot packs are necessary to relieve muscle pain and painful contracture due to poliomyelitis and to prevent deformities. Mild sedation will achieve the same results with much less discomfort to the patient. It is hard to believe that

immobilizing an acutely ill person in ritualistically applied hot fomentations has any value. The patient can be treated just as effectively without these packs, as many reported series show.[9]

3. *Prostigmine.* Prostigmine has recently been advocated for the relief of "spasm" and contracture.[14] Its use in several patients produced no beneficial effect. The patient often complains that he "feels jumpy all over" and is uncomfortable because of the increased sweating and increased intestinal peristalsis.

4. *The respirator.* There are few things in the realm of therapy which have received more publicity and none which have been more widely misused than the respirator. No patient should be put into a respirator unless definite indications are present. Once these indications have appeared, there should be no delay.

All patients, both paralytic and bulbar, who are developing respiratory embarrassment because of intercostal involvement are candidates for the respirator. If the respiratory difficulty is purely central in origin, the respirator is contra-indicated. This patient cannot be trained to breathe with the machine because the irregularity of his inspirations is dependent upon the irregularity of central stimulus rather than upon lack of oxygen. Consequently he fights the respirator and if he was not worn out when he was put into the machine, he soon becomes so. Furthermore, the negative pressure created renders the nasal suction less effective and furnishes an excellent means of producing an aspiration pneumonia. Therefore the respirator is not used for any patient with a purely bulbar poliomyelitis.

The patient who is insufficiently oxygenated because of intercostal involvement will, long before paralysis is apparent, develop signs of anoxia. He is restless and has a definite feeling of oppression. He begins to have slight difficulty in speaking and swallowing because he cannot hold his breath. Respiratons become more rapid and shallow. Gradually he becomes cyanotic and has air hunger. Needless to say the time to put the patient into the machine is early. If he is blue and gasping it is not so much a sign that the respirator should be used as that it should have been used long before.

No one should attempt the care of the patient in the respirator until he is thoroughly familiar with the machine. When the patient first enters he must be taught to let the machine do the work. Otherwise he will become panic-stricken and will wear himself out fighting for breath. He must learn to speak and swallow on the proper phase of the action or he may choke. Positive pressure is unnecessary and inadvisable inasmuch as the expanded chest will collapse passively. Enough negative pressure, usually 10-15 lb., should be used to make the patient comfortable. Too great an excursion may produce emphysema or even rupture the lung parenchyma so that air embolism may result. If the proper choice of case has been made, spectacular relief will be observed within a few minutes.

As soon as the patient can tolerate easily the complete release of pressure which results when the various portholes are opened, the machine may be turned off temporarily. At first this will be possible for only a few seconds, but gradually the time will increase until, as a rule, the patient may be removed permanently from the respirator. This graduation also requires a good deal of careful supervision.

Convalescence: Patients who are discharged, even at the end of quarantine, are not ready for unlimited activity. Even if they have no weakness, they all have stiff backs and varying degrees of "spasm" and pain. These symptoms will usually subside spontaneously, but if the patient is too active they may become extremely disagreeable and physical exertion must be curtailed temporarily. That the disease is still active is shown by the persistence of spinal fluid changes and by the findings in some few postmortem examinations done 3 to 18 weeks after onset.[15] Therefore several weeks in bed at home followed by a gradual resumption of normal occupation is advisable. If involvement is considerable, the patient can re-enter the hospital so that his activities may be supervised and directed from the start. This procedure often prevents the establishment of bad habits of locomotion. Few patients will require this detailed type of supervision which can be carried out either by the attending physician or by a physical therapist.

It is not within the scope of this paper to discuss in detail the convalescent care, but there are

two things which should be emphasized. When a patient is hospitalized with an acute spectacular disease it is easy to forget that all the rest of the time he is an ordinary person subject to the ordinary ills of everyday medicine. Once he is convalescent the opportunity for a complete evaluation of the patient's general condition should not be overlooked.

Second, no matter how conscientious the examiner, he is limited both by the grossness of the examination possible and by the generalized weakness of the acutely ill patient. Patients who are discharged as completely cured or as non-paralytic may reveal a slight weakness some weeks or months later when they are back on their usual schedule and the rest of their muscles have recovered their normal tone. It is therefore absolutely essential to re-examine all patients at an interval of 2 to 6 months for a couple of years before it is safe to conclude that they are cured.

Comments: The method of care outlined is one which is possible in any hospital and which is productive of as good results as any other. In the series of 70 patients to whom it was applied in 1943,[9] there were only 6 deaths (8.6%). Of the survivors 89.1% were completely normal or had only a slight residual weakness 18 months after their original attack, and this number is increasing as more patients are re-examined. There are 7 patients (10%) who are handicapped and who will probably need braces or surgery. These percentages compare favorably with the analyses of "Kenny treated" cases. Pohl claims for Miss Kenny's first 26 cases in this country only 10 recoveries after 18 months and an average hospitalization of 179.5 days.[16] Dyson, reporting on 39 patients treated at "Kenny Cottage," lists 23% with residual paralysis one year later and an average hospital stay of 61.1 days.[17]

With the method outlined the hospital stay was unusually short. For the non-fatal cases, including readmissions for supervised physical activity, the average was 17.9 days.[9]

While the care of acute poliomyelitis inevitably calls for a fairly large staff, it can be seen that the method of suportive therapy which is presented can be administered by a much smaller group than that required for individual hot pack therapy. When time and personnel can be reduced without danger to the patient, there is little room for argument.

SUMMARY

Proper care of acute poliomyelitis consists in general medical and nursing supervision. Special apparatus and specially trained personnel are neither necessary nor productive of a higher percentage of recovery. The amount of recovery of any patient depends entirely upon the amount of initial damage to the central nervous system.

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MENTAL ILLNESS AS A POST WAR PUBLIC HEALTH PROBLEM

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The present war has brought into focus various aspects of mental illness that have heretofore remained dormant or have been relegated to position of lesser importance. This has probably been due to the lack of education of both the medical profession and the general population. The selective examination of many millions of men for the armed forces has uncovered an extraordinary frequency of mental ills, maladjustments, and personality problems which not only make these individuals unsuited for military service, but also constitute every day medical challenges. With the termination of the war we will have in addition to these cases, those problems of mental health relating to readjustment of both military personnel and civilians to peacetime living — mental health of the physically maimed and mental health problems arising from new attitudes and modes of life that may result from this conflict.

In this paper I wish to bring to attention some practical considerations of these matters and to point out preparations that need to be thought of to meet the needs. In order to do this, the subject matter can be divided into the following topics:

1. The extent of the problem of mental illness following the war, in light of past trends in mental illness and already existing conditions.
2. Mental illness as an extramural problem.
3. Prophylaxis in mental hygiene.
4. The relationship of private practice and public welfare practice following the war.
5. Post war planning for mental hospitals.
6. The future of extramural care of the psychotic patient.
7. The veteran and the future practice of medicine.

To elaborate on the first of these topics, I quote from a paper, "Rehabilitating the Psychiatrically Handicapped," by Luther E. Woodward, of the National Committee for Mental Hygiene: "One and a quarter million men, or 13% of all those between the ages of 18 to 38, coming up for induction board examinations, have some mental or emotional handicap which is believed to make them unfit for military service. In addition to these, nearly one half, that is, 45% of medical discharges from the armed forces, are for some neuropsychiatric condition. Already by March of 1944, about 300,000 men had been discharged for psychiatric reasons and about 30,000 were being added to this number each month. It is known also that while no trustworthy statistics are available, sizable numbers of people, both men and women as civilians, have suffered mental breakdown or other forms of pronounced nervous instability."

Men in our armed forces have had many new experiences, one of which has been their contact with psychiatrists for the first time in their lives. To say that all of these contacts have been favorable or pleasant would be an untruth. We know that because of the large number of men handled by psychiatrists, both before and after induction, that psychiatrists have not been able to give their best service. Undoubtedly, however, the psychiatrist has played and is playing an important role and is doing excellent work with the servicemen. These millions of men who have already had contacts with psychiatrists have learned the functions and potentialities of psychiatric treatment. The future will therefore see many more applications for psychiatric treatment directly from these men and from their families, since many of them have learned to accept and understand the value of psychiatry.

The writer and Mr. Harry H. Harman, Chief Statistician, have recently presented "An Analysis of Admissions to Illinois Mental Hospitals: 1922-1943." This paper embraces the admissions to ten state hospitals in Illinois, with a current resident population of 31,000, which represents 90% of the institutionalized mentally ill patients in Illinois. During the period studied, first admissions rose steadily with an exception of the last three years, when there was a decline. The low point was 4,284 first admissions in 1924, while the peak was reached in 1939, with 7,264. If these past trends were to continue and if assumptions could be made from such arithmetic data, all first admissions, which almost doubled

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in the past 20 years, would again almost double by 1960.

Adding up the mental hygiene cases uncovered by selective service, the neuropsychiatric war casualties, the population's familiarization with psychiatry, and the trends in state hospital admissions, it becomes evident that the treatment needs for mental illness and social maladjustment will be out of proportion to the existing facilities and will be a serious stumbling block in the post-war world. This psychiatric task places upon the medical profession the burden of stimulating and completing the training of new psychiatrists. However, psychiatry cannot expect to solve these problems unaided. The medical profession has been guilty of overlooking and neglecting important resources that can and should be utilized in achieving the goals of mental hygiene. We have learned from experience with treating large groups of the mentally ill, that we can profit by enlisting the aid of professions that stand at our side, professions which are allied to the medical disciplines and which are concerned with education, rehabilitation and treatment of the maladjusted persons. These professions include clinical psychology, vocational guidance and adjustment, social work, recreational therapy, occupational therapy, arts and crafts and religion. We have long had an essential working relationship with the profession of social service, although there still remains much to be done in the way of ironing out working plans. Clinical psychology is now assuming an important role in the work united toward a common objective, and vocational guidance has become indispensable because of its timely application to the returning veteran. Many major clinics already employ vocational specialists, occupational therapists, recreational therapists, and social workers, along with psychiatrists, to give a more rounded service to the patients.

Mental illness as an extramural problem: Since the beginning of this century, there has been a gradual increase in the number of patients in institutions. The cause of the increase can be attributed to several factors, such as the increased recognition of mental illnesses and the growing awareness of the need for treatment of these cases. It became evident that unless we altered our philosophy in regard to the care and management of the mentally ill, the state would need to continue to increase its facilities for this type of patient even out of proportion to the upward trend of institution population. It would mean the enlargement of state mental hospitals that had already become almost too large with populations averaging 4,000 patients. Other countries, as well as a few institutions in this country, tried out the plan of providing family care rather than institutional care for suitable cases. They found that in addition to the advantages gained by handling smaller numbers in the mental hospitals, distinct benefits accrued to the patients. Chronic, stagnant patients were often stimulated by a fresh, more normal environment, and were able to make adjustments good enough to enable them to remain out. In some of these cases recoveries occured. The state of Illinois has within recent years adopted this philosophy and has laid emphasis upon extramural care of patients as well as upon bettering the existing facilities of mental hospitals, thus keeping the population at a rather stationary level. Such a plan places an increased responsibility upon the family of the patient as well as the community from which the patient comes.

Because more patients are being returned to the community than in the past, the communities have been and are being educated to their responsibility in caring for the mentally ill, and in some instances are giving wholehearted cooperation. We have seen that although some patients are unable to perform as well as they did prior to the onset of their illness they are still able to do a useful piece of work toward the war effort. Since communities have begun to accept responsibility in the care and management of psychotics, they are also rapidly becoming aware of the lesser mental illnesses, such as psychoneurosis, epilepsy and mental defieiency.

One must not lose sight of the great strides that have been made in the past decades in the field of child guidance. The community again comes into play in taking over a great part of this task. The State of Illinois has already organized out-patient clinics operated by the state mental hospitals for adults and by the Institute for Juvenile Research for children. But we are only scratching at the surface with our limited number of such clinics. We can envisage for the future the ultimate goal of having

an extramural clinic for mental hygiene problems established in each county, which would meet at least once a month. More densely populated counties would need to have clinics scheduled more frequently. This does not mean that these medical and allied services need necessarily be state maintained or state supplied, but that private practice should recognize and contribute to these needs on a private practice basis.

The above subject of community responsibility and community facilities in mental hygiene is closely allied to our next topic, "Prophylaxis in mental hygiene." We have learned in psychiatry that early treatment of mental hygiene problems can be compared to early treatment of somatic illnesses, that is, early recognition and adequate management of behavior difficulties, emotional problems, delinquency experiences, and social maladjustment, may prevent more serious developments such as criminality and crippling psychoses or psychoneuroses of the adult. With the growth of facilities in psychiatric practice, there will be increased attention to prophylaxis. A concrete instance of prophylaxis in mental hygiene is the already noticeable decrease in the number of admissions to state institutions of cases of general paresis. This decrease may be a result of the propaganda directed toward the control of syphilis: the nation-wide practice of frequent blood tests followed by adequate treatment in positive cases, and, particularly in the use of fever therapy, in cases with positive spinal findings, prior to the onset of central nervous system symptomatology. These things have undoubtedly been important in the reduction of admissions of general paresis to the comparatively low figure of about 600 a year. Continued stress on this program should help to bring this type of mental illness to the vanishing point. We are, of course, not as successful in prophylaxis in other conditions since we do not have such tangible methods or means to combat other types of mental illnesses, but still we must pattern our prophylaxis program upon this and other principles of preventive medicine. It is not the purpose of this paper to delve into those concepts of psychiatry which have to do with prophylaxis but it suffices to state that such tools are available.

For years prior to the war there existed a sometimes unfriendly relationship between physicians in private practice and those making a career in state or other welfare divisions. There was little understanding by each of the problems which formulated the other's particular kind of practice. The physician giving full time to the salaried position in a large hospital had the problem of treating large groups of patients and still maintaining the standards of individual treatment. The physician in private practice had the problem of combining the dictates of sound medicine with meeting the eccentricities and demands of the private patient and his family. With the war the relationship between the private practitioner and the salaried physicians has altered somewhat. In the first place the two have to call upon one another more often for help. Secondly, the one has become more familiar with the other's type of practice. Private practitioners have consented to take on part time paid jobs and men holding full time jobs were given the opportunity to explore private practice. Resentment of this changed situation has been only negligible at the beginning. Colleagues are beginning to understand one another to a fuller degree. Men in private practice are no longer dubious about the type of treatment received in institutions and therefore help to promote better relationships between families and institution personnel. Men practicing in institutions encourage people to seek medical care from private practitioners, since they are developing a greater sympathy with them. The post-war period should strengthen these bonds and should promote even closer relationships for the mutual benefit of private practitioners and salaried physicians. The state-operated institution or clinic is no longer a threat to the private practitioner. On the contrary, it is becoming a resource for him, in that he is able to refer cases to the clinic and is also able to receive patients from the clinic who are referred to private practice.

As has been pointed out above, the tendency in the State of Illinois is not to enlarge the existing institutional facilities but to better those which we already have. The Department of Public Welfare has already outlined some of its post-war plans which provide for a larger treatment program in its institutions. Let me cite some statistics in regard to the cost of our state institutions. These institutions are worth one hundred million dollars as they now stand.

While private industry appropriates approximately 4% of the total of its asset values for "upkeep," the State of Illinois appropriates only 1% for repair and upkeep of its institutions. Over the years, this has obviously resulted in some depreciation of the institutions of Department of Public Welfare and hence it is now requesting an appropriation of seventy million dollars in its post-war planning budget to help to recuperate the losses suffered in bygone years. This money will be spent not so much in increasing the number of beds as in improving the buildings and, to quote, "increase the space between beds so that one can walk between them forward instead of sidewise," and to enlarge treatment facilities.

There are, however, provisions being made for an increase in the number of beds for tuberculous patients and for the care of returning mentally ill veterans of World War II. The plans call for 1,400 additional beds for tuberculous patients and 600 beds for veterans. The improvements will consist also of enlarging occupational and industrial shops and programs already in existence, adding additional acute hospital and infirmary buildings, installing improved x-ray equipment, enlarging existing laboratory facilities and increasing staffs of physicians, nurses, laboratory technicians, psychologists, occupational therapists, recreational therapists, etc., in order to meet standards set by the best modern hospitals. For those who might wish to have further reasons for an increased expenditure in the maintenance of state institutions, I can quote figures from a survey* made by Laura Fitzsimmons covering per capita maintenance cost of mental patients in state hospitals of the various states for 1939. The State of Illinois at that time had a per capita cost of $255.47, while Wisconsin spent $572.17 and Michigan $505.34 per patient. I am comparing these two states because of the similarity in population and wealth of these states as compared with Illinois.

In an earlier portion of this paper some aspects of extramural care were discussed which can at this point be elaborated. As has already been brought out, we have learned that adjustment of the mentally ill in the community has been less of a threat to the community than was expected and has also been beneficial to patients. In post-war planning cognizance should be taken of the possibilities of enlarging this program and further utilizing the "Family Care Plan." Under this plan, patients who can derive no further benefit from hospitalization and who are not a danger to the community but are unable to support themselves, are boarded out with interested families. Payment for the support of these patients is made at the same rate as it costs to maintain the patient in the hospital. This is done if there are no interested or able relatives. The hospital retains its original jurisdiction over the patient in a supervisory capacity by maintaining close contact with the patient and the foster family. Any diagnostic group of patients are suitable for this kind of care, but the senile and arteriosclerotic groups seem fairly well adapted for such management. There have been conflicting opinions in regard to where the responsibility lies for the care of those aged who have the misfortune of becoming invalids as a result of the changes of senility.

It would seem that families have a responsibility greater than that of the state to provide for their aged. On the other hand, a senile psychotic can be as great a problem as any other psychotic patient. The solution of this controversy lies in a middle course; that is, encouragement of families to care for their aged whenever this will not interfere with a normal mode of family life nor the rearing of children in the family. It is not wise to instill guilty feelings in families so that they are unduly burdened with the care of senile patients, but in some cases a little education as to the needs of the senile, understanding as to the causes for the mental infirmities concommitant with senility, and instruction as to how to handle wandering, loss of memory, changes in personality and untidiness, may enable families to care for their senile relatives and thus decrease the population of already overtaxed mental hospitals.

The last topic of this paper is the veteran and the future practice of medicine. "The recent wars in which this country has been engaged were followed by the development of federally controlled and staffed medical programs for the veterans of these wars. This program has been largely centered in the Veterans' Administration. The present war will greatly increase the amount

* "Report of a Survey of Nursing in Mental Hospitals in the United States and Ontario, Canada," Laura Fitzsimmons, R. N. American Journal of Psychiatry, March, 1944.

of medical practice of this type. The prospect is that upward of 13 million men and women will have a right to full hospitalization benefits for both service-connected illnesses and other illness that may develop after the return of the veteran to civilian status. There is unfortunately, insufficient relationship between the general medical profession and that part of the medical profession found in the Veterans' Administration. If the private practitioners of medicine — psychiatrists, other specialists and general practitioners — were to play a more dynamic role in promoting the total welfare of the sick veterans returned to civilian life, two beneficial results would follow. First, a large proportion of medical practice would remain in the category of private practice, and second, a larger portion of the veterans would make a better civilian adjustment characterized by less psychosomatic illness and less dependence upon governmental subsidies. Some industrial physicians have already taken the lead in placing physically handicapped war-injured, and also industrially-injured men, into industrial work-situations formerly thought to need workers free from handicaps of major extent."* The same idea applies to the psychiatrically handicapped, except that the proper placement of the psychiatrically handicapped often proves a therapeutic measure for the patient as well as gainful for the employer.

The soldiers, sailors and marines now fighting are exposed to unfortunately contradictory life experiences. Young men who were formerly brought up in this country to be peaceful, cooperative and constructive citizens, are now going into a war in which the nature of the enemy and the fighting of the enemy is such that everything they have learned that is constructive and peaceful has to be — temporarily unlearned and replaced by shrewd cunning and beastly warfare. They will return to us needing to unlearn these beastly practices,"* and also to overcome the emotional traumata incident to the fears, hates, despair and shocks of death and disaster that they suffered during combat. The mental health problems of these men will be many and it will take much effort on the part of the medical profession to alleviate their problems and to accustom them to civilian modes of life. Many service men went in as boys but will emerge as experienced men who have not had the benefits of more normal transition experiences. They may be unable to cope with civilian demands and competitions. They will not be satisfied to return to their former social and economic positions in life. The economic adjustment following the war may be such as to further increase their conflicts.

The returned veteran's attitude toward the medical profession itself may be an unusual one. A colleague informs me that perhaps because of the pressure of non-medical officers, the medical officers of his particular camp assume, until the contrary is proved, that psychosomatic complaints are usually faked. He says, "The more I see of the Army doctor, the more I dislike him. The Army physician is building up a tremendous reservoir of ill will toward himself by believing many men to be malingering and telling them so. The men are treated roughly. Eneuretics are given none too gentle cystoscopies, the headache brigade is given painful foreign protein, or sulphur shots, etc. The result is a fear and distrust of medical men." My colleague modifies this statement by saying the closer one gets to the front, the less true this situation becomes. This may account for the over-indulgent attitude in the Veterans' Administration: an over-correcting attitude developed whereby the veterans when they get out become very demanding and the Veterans' Administration gives an indulgent and infantilizing medical program which attempts to make up for and compensate for the things done to the men while in service. I suggest that physicians become better acquainted with the rehabilitation programs, national, state and local. They might become acquainted with service officers and learn what they do for veterans. For instance, they might become acquainted with veterans facilities which so often in the past have had poor medical programs. They might learn more about vocational rehabilitation and employment programs, about benefits and claims, and disabilities, about the relief and case work administered by the American Red Cross and other agencies serving the veterans and their families. It is by first becoming acquainted with the already exist-

*"The New Veteran and the Future Practice of Medicine," Conrad Sommer, M.D.

ing conditions that we can build more constructive plans.

Before concluding I wish to outline the present trends in rehabilitation. It is unfortunate that as yet there has not been established a smoothly operating machinery for the guidance or rehabilitation of returning men. A soldier coming back, if he is not suitable for hospital care because of the ambulatory nature of his disability, may go to several agencies for aid in Illinois, such as the American Red Cross, the Division for Rehabilitation, the Veterans' Division, the Veterans' Administration, private clinics or state clinics, newspaper operated bureaus, employment bureaus and others. As yet, the functions of each of these organizations have not been clearly defined and coordinated. Before long the veteran has been sent from one to another and begins to feel that he is being given "the run-around." Many attempts have been made and are being made to remedy this condition, and although some progress has been made there remains some confusion. I have seen many cases that have had contact with a number of agencies without finally coming to the proper one.

To meet the need for rehabilitation there have been organized psychiatric clinics whose sole function it is to return the veteran to his preinduction emotional and vocational state or to start him on the road to a mode of life superior to that which he left to enter the service. Brief psychotherapy augmented and assisted by social worker counseling, psychological testing and vocational guidance and some occupational therapy, are the techniques used in the clinics. Such clinics have been given impetus in scattered sections of the country and are increasing rapidly in number although they are still far too few to handle a substantial percentage of men returning with a need or desire for rehabilitation. Those of us who are working in clinics find that there are cases of neurotically disturbed veterans and civilians who are too ill to be treated outside of a hospital but who do not classify in the usual mental hospital. For this group, an intermediate institution where the patient would receive the benefits of medical and adjunct services would be a worthwhile undertaking. Patients, as they improved, could make a graduated return to the community passing through an interval stage where they would work outside of the hospital but live within the hospital until enough security was gained to return to an independent life. Such hospitals are operating successfully in England, where both civilians and veterans are treated under the same roof.

In summary and conclusion this paper has endeavored to indicate the extent of mental illness to be expected as a post-war Public Health problem, the responsibility of the community, the State and private practitioners in meeting this problem, post-war plans for the treatment of the mentally ill, and the special needs of veterans in the field of mental illness.

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A DISCUSSION OF LACRIMAL PROBLEMS

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I wish to thank you very much for inviting me to your meeting. The death of my brother, Sandy, is a tremendous loss to your city and state. Since his place can never be filled, we will all have to do just a little more of our own thinking. He was a great teacher and a true friend to all of us. I, personally, owe him a large debt for his good advice and counsel, which has helped me over a good many bad spots in the road.

The tear sac region is a sort of no-man's land between the eye and the nose and throat. I am afraid there has been too much fighting over who is the proper authority. Also, there is the opposite feeling of "let the other fellow do it." I feel that this is primarily an eye problem. The patient comes to the eye doctor because of tearing and wants something done about it. He rarely understands that the tears have any connection with the nose. The doctor who does eye and nose and throat work, is ideally situated to understand the problem but rarely has the time or energy to work it out carefully. This places diseases of the lacrimal apparatus in the lap of the ophthalmologist. He should devote more of his time to a better understanding of the problem, and cooperate with the nose and throat doctor in solving it.

The problem divides itself into three parts: (1) too few tears, (2) too many tears, (3) in-

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fection with pus or mucus in tear sac. First, I would like to discuss the dry eye where there is too little secretion and the corneal epithelium actually suffers. These cases in the final stages are known as keratitis sicca or filamentary keratitis, and as such are a definite syndrome with definite treatment. You have all seen these cases with the symptoms of burning, smarting, photophobia and poor vision. They are usually of many years duration, characterized by a ropy elastic secretion like vernal conjunctivitis but without eosinophiles. These strands hang on the cornea along with multiple punctate defects in the epithelium. Some strands are actually made up of rolled up corneal epithelium. The conjunctiva is injected, looks dry. You can almost spot one of these cases from across the room since many are badly crippled with arthritis. The smears have many epithelial cells and few polys. I see about one typical case a year. The treatment is closure of the puncta as suggested by Dr. Beetham. The puncta are closed with diathermy cautery under local anesthetic. This is an office procedure. The vision in some cases may improve from 20/100 to 20/30. This procedure is also of value in neuro-paralytic keratitis, trachoma and pemphigus, where a lack of tears is a contributing factor to the keratitis.

Sleep causes a lessening of lacrimal secretion and the dry feeling associated with fatigue and sleepiness is due to a definite lack of secretion. This is a common distressing symptom of older people. I dislike giving eye washes to be used indiscriminately and with no specific reasons. It is a bad habit, and if the symptom is neurotic in nature, using drops increases the patient's consciousness of his eyes and exaggerates the symptoms. The use of 3% saline (slightly hypertonic) pulls fluid out of the tissues and the relief lasts for some time.

There is another borderline class of cases where on awakening, the patient has a sharp pain. The pain may wake the patient. These people have small epithelial erosions with staining and non-staining opacities in the lower third of the cornea. I feel these defects are associated with a lack of tears during sleep and partial opening of the lids with drying of the lower cornea. An ointment, — I use Quinine Bisulphate 2% or mineral oil at night — does help these people. These are the common problems associated with too few tears.

The problem of too many tears is much tougher. I have tried to work out a diagnostic system that would give definite answers, but so far have failed. There are too many uncontrollable and unknown factors.

Hypersecretion of the gland itself undoubtedly causes tearing but I know of no diagnostic test to prove this for an individual case. If the drainage apparatus is functioning and there is still too much fluid to be carried off, the patient complains of tearing and we *say* the gland is secreting too rapidly. It is believed that normally the orbital part of the gland only functions under emotional or irritative stimulus and that the accessory and conjunctival glands maintain the general lubrication of the eye. How is it possible to separate these functions and say whether one or the other is excessive? It is believed that the ordinary secretion is motivated by the sympathetic nerves which control the vascular supply to the gland and the copious emotional flow is controlled via the para-sympathetic. But this is still debatable and facts are still lacking.

In practice, I believe it is a rare occurrence to have prolonged tearing of nervous origin. (True lacrimation). I remember one case of a young girl with swollen glands in the neck and unilateral tearing for ten days. This stopped spontaneously when the swollen glands disappeared. No cause was found. If lacrimation were common, removal of the gland or section of the excretory ducts would have become a more common procedure. Perhaps it should be.

The only recent cases reported are nine of Jameson's where the ducts were sectioned with no complications and relief of tearing was accomplished. Wheeler advised this procedure after removal of the sac and reports no difficulties. This procedure has not been generally accepted and I have done this on only one case with slight decrease in the tearing. This should be worked out more carefully. The technique is simple.

With so little definite knowledge about secretion of tears, it makes the study of drainage difficult. In attempting to establish a basis for normal physiologic drainage, I have tried to correlate the size, shape and position of the puncta

with its ability to carry tears. This sounds easy and if the puncta is turned away out on the face it is easy; if it is only a little way out and very small, it may fool you completely.

One drop of fluorescein dropped into the conjunctival sac will normally run into the nose in sufficient quantities to be blown out on a piece of kleenex in three minutes. I have determined this as a base in many normal people. If the test is positive, you can be pretty certain that normal drainage is taking place. If it is negative, I do not know yet how to evaluate it. I have seen several negative tests, that is no fluorescein comes through in five minutes, where irrigation with a lacrimal syringe shows not the slightest resistance. These people may or may not complain of tearing. If there is no complaint, the conclusion is justified that in spite of poor drainage there just are not enough tears to run over. These are the patients who do not complain of tearing after removal of the sac. If tearing is complained of the conclusion is indefinite. There may be excessive secretion for that particular drainage apparatus. There may be faulty capillary attraction at the punctum due to faulty position or size, or there may be lack of pump action in the sac. Any of these conditions may exist, and without definite evidence of faulty position not present, as an ectropion, I know of no method to make a definite diagnosis. Therefore no treatment can be successful. Tampering with the punctum by slitting or cutting out a triangle, should not be done. My father did this on many people and I see them now with their tears still present. If the position is slightly faulty, diathermy cautery on the conjunctival side to turn it in, sometimes is beneficial but not always, as there are other factors present in some of these cases. I usually pass the buck and do nothing. No harm results, but the patient also gets no results. Frankly, I do not know, but after some more study on this, we may find out what to do.

If saline cannot be irrigated into the nose, then definite obstruction exists and diagnostic probing should be done. The probe should go no farther than the obstruction because it can cause more damage to structures beyond. Frequently the obstruction is in the lower canaliculus just where it joins the sac or beyond the junction with the upper. In this later case, the solution washes out the upper canaliculi and not back along the lacrimal tip. The probe feels this obstruction easily and does not touch the hard wall of the nose. The lid moves when the probe is pushed. I do not know how to cure this type of obstruction other than by forceful dilatation with blunt probes against the side of the nose, not down into the sac. Because of the right angle turn at this point if the probe does not enter the sac, it will make a false passage when turned downward. Horizontal probing is occasionally successful. If it fails, I know of no method of attack other than the extensive operation of Aruga, which looks good on paper. He removes the sac and sutures the canal to the edges of the nasal mucous membrane after cutting a large bony window into the nose. (I have a slide of this procedure.) These cases with obstruction in the canaliculus never get infected and are not dangerous, so I have done nothing with the few I have seen. A delicate plastic operation, using the upper canaliculus, should be worked up by some industrious intern. I have tried to use the upper one as an extension of the lower to reach into the nose, but could not do it.

The stricture may be found lower down in the sac at its junction with the naso-lacrimal duct. This is the common place for it because of an anatomical narrowing at this point. With obstruction here, a mucocele or acute infection will eventually develop. The development of the pathology after an obstruction has occurred is not clearly understood, and is certainly different and variable in different cases. The usual course is tearing for several months followed by a little collection of mucus and the gradual development of a mucocele from chronic infection. This is the same course that is seen to develop in infants where the lower end of the duct fails to open soon after birth. In treating infants I made the discovery that pressure on the sac down toward the nose would produce an immediate cure in some cases. Almost like "The laying on of hands" of medieval times. You may all know about this but it was new to me. I have followed this practice for the last few years with almost universal success after one, two or three trials. In looking up our cases (37) I find there were 8 cases where this produced a cure. Surprisingly enough, there were 11 cases that

either were cured spontaneously or were cured by the mother. She was advised to empty the sac by pressure and use a mild antiseptic, zinc sulphate 1/5th percent. Eighteen cases were probed with success in 14 cases. The only 4 failures were in this group. Maybe these were the tough ones, but I have a feeling that too early probing is dangerous and may cause enough damage to start a permanent stricture.

These failures were all probed under 6 months of age and I believe now that no probing should be done before this age. If pressure is applied properly at intervals of one to two weeks, I do not believe many cases will need to be probed.

In the adult a cure by pressure cannot be expected since the obstruction is higher up and has no tendency toward spontaneous cure.

A mucocele may be carried for years without any acute infection, or it may suddenly become acute at any time. This may rupture or is opened surgically to be followed by repeated similar attacks and the development of a fistula on the cheek. If the infection is extensive the entire mucous membrane of the sac is destroyed, leaving only tearing and no further mucus or possibility of infection. This type is difficult to recognize after it has healed. It is not considered in most discussions but I have seen several of these in our series of cases. Some of the cases where the probe does not enter the sac are of this type and not a simple stricture of the canaliculus. Further probing in these is hopeless and only the Aruga operation offers much if any success. There is no infection here, and little danger of it, so nothing is usually done for these people.

For the cases of early obstruction before a mucocele or infection has occurred, I am also at a loss to know what to do. Probing may be tried a few times but offers little success, and usually ends up with an infection or mucocele later, as the case histories of many patients will show. I have almost reached the point where I believe these patients should be left without interference until a mucocele or infection takes place. Since then surgery offers a high percentage of cures, while if undertaken at this stage it has not been very successful. These cases are the hard ones. Tearing, but no mucocele, and with evidence of obstruction low down in the sac. I hope someone here can help me with this problem.

The acute case of dacryocystitis should be handled medically if discovered early. The sulfa drugs should help here. I try to empty the sac by gentle pressure and washing, but do not try to probe beyond the canaliculus. This end gets blocked by kinking and edema and can sometimes be opened by gentle probing. If the sac can be emptied without incision it often drains after the infection subsides. If this fails, the sac should be incised deeply and sulfanilamide powder dusted in or carried in with a drain. From two to four weeks after it is healed, the status should be surveyed and if a mucocele is present a dacryocystorhinostomy should be done, or if the sac has been completely destroyed, nothing further is needed unless tearing is extensive. Then the Aruga technique or section of the excretory ducts could be done.

The cases of mucocele offer no real problem. A dacryocystorhinostomy should be performed which will cure nearly 90%. The only reason for failure in these cases is faulty surgical technique, or anatomical variations.

The basis for my opinions on this subject is a series of 85 cases of lacrimal obstruction that Dr. Stokes and I have operated on in the last nine years. The technique of the operation is simple, really much less difficult than removal of the sac. We use a plan very similar to that which Dr. Burch described in 1920. This may have been original with him but the idea was first tried by F. Speciale in Cirincione's clinic in Italy in 1904. Toti's work came out in this year and further work on this method was dropped in favor of Toti's method. Forsmark in Sweden and Neumayer in Germany, did a similar operation in 1911. After 1920 this type of operation was reported for many different countries. Dr. Stokes got his inspiration from the work of Stock, published in 1934. I helped Dr. Stokes with some of his early operations and realized how much simpler it was than the Toti-Mosher type I had been taught to do in Boston. This operation we call a transplantation operation. It is really an implantation but transplant is the more common word and nearly as accurate.

The lower end of the sac is freed through an external approach. An 8 mm. trephine opening is made into the nose. The open lower end of the sac is held in place in the nose by sutures pulled out on the cheek. The details of the operation

are published in the Transactions of the American Academy of Ophthalmology and Otolaryngology for 1938 and in the Archives of Ophthalmology of August 1939. At that time Dr. Stokes reported 39 operations. Our recent series of 85 includes these cases with a further follow up. I will not have time to go into the details of the operation but these slides and the movies will show the important points.

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SULFATHALIDINE: CLINICAL EVALUATION IN INFECTIOUS DISEASES OF THE COLON

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You no doubt are familiar with the recent reports of the progress in the use of "sulfasuxidine" in diseases of the colon. The results that were published were in agreement essentially in that sulfasuxidine was acknowledged as an intestinal antiseptic, that it had bacteriostatic properties and that it was superior to any derivative of the sulfa group in use in the past. We have employed succinyl sulfathiazole in 107 patients and have reported (1943) bacteriologic studies on many stools — and also carried out blood concentration levels. The dosage employed was .25 G per kilogram of body weight per day. In spite of the large doses employed no toxic manifestations were observed.

Because of the necessity of employing exceedingly large doses of sulfasuxidine to obtain the optimum effect, it seemed desirable to develop a new drug, one that would be of similar properties and equally as effective in smaller doses.

Recently sulfathalidine a new sulfonamide has been developed. This new compound is similar to succinyl sulfathiazole chemically and therapeutically — it is a derivative of sulfathiazole and is known as phthalylsulfathiazole. The effective therapeutic dose of the new compound is approximately one-half that of succinyl sulfathiazole (.125 G per Kilo body wt.). Ross and Poth reported in 1943 that "Sulfathalidine" is absorbed sparingly from the gastrointestinal tract, that it maintains low concentrations in the blood (.1 to 1.0 mgm.), and is rapidly excreted in the urine; they maintain that the new compound has 2 to 4 times the bacteriostatic activity of sulfasuxidine, and that it has not caused toxic symptoms in man.

At this time we wish to report briefly on the clinical and laboratory studies of 47 patients with infectious diseases of the colon in whom sulfathalidine was employed.

Clinical Report. Of the 47 patients treated with sulfathalidine 33 were female and 14 were male. The dosage used was .125 G per Kilogram body weight administered every four hours. The drug was employed for many weeks in each patient and the study comprised cases of chronic ulcerative colitis, amebic dysentery, bacillary dysentery, paratyphoid and Giardia Lamblia. The following table illustrates the results obtained in the treatment of 47 cases of infectious diseases of colon with sulfathalidine.

In Table 1 we observe that the majority of the patients studied show clinical improvement. We also note that the acute cases improve as readily as the chronic; cramping in the abdomen subsides about 48 hours after administration of the new sulfa drug, blood in the stool disappears, the stool becomes formed, and odorless and the number of evacuations are reduced substantially.

In the acute types the temperature is reduced in 48 to 72 hours after intake of *"sulfathalidine."* Only a small percentage of cases fall into the acute ulcerative colitis type, and the patients observed demonstrate the fact that sulfathalidine has solidified the stool effectively in these types; it has reduced the number of evacuations in the acute and chronic cases. The drug does not elicit any marked toxicity in form of local or generalized manifestations and in this respect compares favorably with sulfasuxidine. We have employed therapeutic doses of this compound in patients for 2 months intermittently.

The bacteriostatic activity of sulfathalidine is demonstrated in Table 2. It is evident that sulfathalidine is strongly bacteriostatic and is peculiar in that its activity is directed primarily against the B. Coli group and subsequently

Presented before the section on medicine at the annual meeting of the Illinois State Medical Society — Palmer House, Chicago — on May 16, 1944.

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TABLE 1

COMPARATIVE STUDY OF THE EFFICACY OF VARIOUS SULFONAMIDES IN CHRONIC ULCERATIVE COLITIS

NAME OF DERIVATIVE	TYPES OF COLITIS		RESULTS		
	Acute	Chronic	Good	Fair	Poor
					12A*
Sulfanilamide	12	5	2C*	1C	2C
			3A		6A
Sodium Sulfathiazole	9	6		4C	2C
			4A	8A	1A
Sulfaquanidine	13	10	9C	1C	
			27A		12A
Sulfasuxidine	39	68	48C	14C	6C
			11A	1A	
Sulfathalidine	12	35	26C	4C	5C
			45A	9A	31A
Patients in Each Group	85	124	85C	24C	15C
Total Number of Patients		209	130	33	46

*C — Chronic
*A — Acute

against other bacterial invaders (streptococci, staphylococci, and others). Sulfathalidine has been employed in amebiasis, bacillary dysentery, paratyphoid and Giardia Lamblia to some advantage — as in the case of sulfasuxidine, the new sulfonamide is not specific in infectious processes just mentioned, but is of aid in that it minimizes the extent of the ulcerative lesions by reducing the number of secondary invaders.

In the management of ulcerative lesions of the colon we are one step further with the advent of the recently developed aids such as sulfasuxidine and sulfathalidine. The sulfonamides must be reinforced by supportive measures of blood transfusions, intravenous administrations of saline and glucose solutions, and intramuscular injections of liver extract. Further, a diet of low residue and high calory supplemented by

TABLE 2

BACTERIAL COUNTS OF STOOLS — BEFORE AND AFTER SULFATHALIDINE

NAME OF PATIENT	Name of Organisms and Counts in Millions (per 1 gram of stool)											
	B. COLI			NON-HEMOLYTIC STREPT.			HEMOLYTIC STREPT.			TOTAL BACTERIA		
	Before	Days on Rx	After	Before	Days on Rx	After	Before	Days on Rx	After	Before	Days on Rx	After
	83.2	2	1.2	.7	2	2.1	.25	2	.25	95.4	2	47.0
M.L.		4	1.9		4			4	.25		4	59.0
		7	0		7	1.0		7	.5		7	22.1
		14	0		14	.5		14	.5		14	.9
	75.0	2	38	8.2	2	8.0	.7	2	20	87.0	2	62.0
J.N.		4	4.9		4	7.8		4	14		4	52.0
		7	24		7	6.0		7	.1		7	23.0
		14	30		14	1.0		14	0		14	13.0
	21	2	.1	.5	2	.1	.7	2	.1	31	2	.4
A.N.		4	.2		4	.1		4	.1		4	.2
		7	.1		7	.1		7	.1		7	.2
		14	0		14	0		14	0		14	0

vitamin requirements must be maintained for long periods.

The criteria that aid in the interpretation of the progress of an infectious disease of the colon are (1) clinical improvement of the patient, (2) proctoscopic changes of the colon (observed at reasonable intervals) and (3) microscopic recheck of the stool specimens.

CONCLUSION

(1) Sulfathalidine is an aid in the management of infectious disease of the colon. (2) Sulfathalidine possesses strong bacteriostatic properties. (3) We suggest that more time be devoted for proper evaluation of this new sulfonamide.

I wish to thank Dr. Milan Novak of the Dept. of Bact. for his advice in the bacteriology of this problem.

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DISCUSSION

Dr. Laurence Hines, Chicago: Have you had experience with the use of these drugs in the acute fulminating type with hemorrhage?

Dr. M. H. Streicher, Chicago (in closing): In answer to Dr. Hines' question concerning the acute fulminating cases with hemorrhage, we have had seven or eight cases which were very severe but without hemorrhage. These were as serious as I have ever seen, having twenty to twenty-five stools a day with loss of thirty pounds in weight and with much cramping, but no hemorrhage. In the severe types of infections referred to by Dr. Hines sulfathalidine in larger doses would not be applicable because some laxative action has been claimed for this drug. But if the dosage is kept down to 3 grams a day the laxative action would be negligible. On this dosage the blood level of sulfathalidine varies from 1.0 to 1.3 mg. over a period from six weeks to three months.

Financial security for the tuberculous person who is hospitalized or whose employment is limited, has come to be a responsibility the public must accept, if control of the disease is the goal of the community. Overcrowded living conditions, poor home hygiene, and fear of want during the absence of the breadwinner from the home all contribute to failures of arrest of the disease in individual cases. Lack of attention to these social and economic factors results in the continued spread of the disease from uncontrolled open cases. Herman E. Hilleboe, M.D. and Arthur W. Newitt, M.D., Journal-Lancet, April, 1945.

CONTINUOUS CAUDAL ANESTHESIA

Paul Pernworth M.D.; F.I.C.A.
VENICE, ILL.

The method of continuous caudal anesthesia so well presented by Hingston and Edwards in their first publication (Oct. 1942) is a skillful technical fusion of two chronologically distant periods in anesthesia. In 1901 Sicard demonstrated the possibility of securing anesthesia of the distal extremities, perineum and lower abdomen by depositing carefully measured volumes of cocain solution in the sacral canal. By 1909, Stoeckel of Vienna had recorded 141 deliveries in which portions of the second stage of labor had been made painless by this means. Both these technics were "single-dose" methods in which the caudal needle was withdrawn after injection. As such the anesthesia produced was limited to the duration of about one hour and frequently much less. In Jan. 1940 Lemmon of Philadelphia presented his technique of continuous spinal anesthesia which was revolutionary in that, for the first time, the surgeon operating under spinal was unhampered by the bogey of having the operative procedure outlast the anesthetic. This increase in the length of anesthesia was effected by the subarachnoid introduction of a special malleable needle which remained in place during the operation, and through which fractional doses of procaine were injected as needed.

Combining these two concepts of (1) caudal route of administration and (2) an indwelling needle, summarizes the newest and most effective method for painless deliveries and for anesthesia in certain regional operative procedures.

To understand the action of caudal anesthesia, some fundamental concepts of applied anatomy are essential. Sporadically during the past ten years, publicity has been given to a type of local anesthesia known as peri-dural or epidural. To those familiar with this term, the present discussion will immediately be clarified if caudal and epidural anesthesia be recognized as identical. To those not familiar, a brief description of the epidural space is in order.

At the foramen magnum the dura mater splits into two layers the outer one blending with the periosteal lining of the vertebral canal while the inner layer forms the tough protective theca of the spinal cord. If these layers are followed

distally we find that the outer one reaches the base of the coccyx while the inner one ends ot the 2d. sacral vertebra. There exists therefore a space between these two layers extending from the base of the skull above to the membrane covering the sacral hiatus below. This is the epidural space, containing fatty tissue, a venous plexus as well as those portions of all afferent and efferent neurones between the spinal cord and the intervertebral foramina. There is a marked negative pressure within this space, a condition utilized to advantage in giving epidural anesthesia by the lumbar or thoracic route. However this epidural space may be entered with greater ease and safety by penetrating the sacrococcygeal membrane which forms its most distal boundary. By introducing the anesthetic from below it is possible to fill first the sacral then the lumbar portions of the space and if desired to flood the entire space up to the foramen magnum by increasing the volume injected. Cathelin calculated that 30 cc. would fill the sacral canal, while 120 cc. would be required to reach the foramen magnum in the average individual. Since all sensory nerves pass from their dorsal root ganglia thru the epidural space to the spinal cord, they would be bathed in any anesthetic solution present there. Similarly with the efferent motor nerves although their thicker myelin sheaths gives them greater immunity to the action of local anesthetics.

Innervation of the Uterus and Vagina. The sensory nerves from the uterus are visceral afferent fibers which although functionally independent of the autonomic nervous system course through their pelvic, hypogastric and aortic plexuses to connect with the dorsal root ganglia of the 11th and 12th thoracic segments. The sensory supply from the cervix and upper vagina accompanies the sacral parasympathetic outflow although it also is functionally independent. The sensory and motor fibers of the lower vagina, perineum and pelvic floor are somatic and travel in the perineal and pudendal nerves. The motor supply to the uterus is autonomic involving both sympathetic and parasympathetic components. Clinical evidence indicates that these neurones leave the cord at levels above the 10th thoracic and perhaps even as high as the 6th then pass downward through the pelvic aortic and hypogastric plexuses to the uterus.

Equipment and Technique. When labor has become established, the anesthetic may be started and continued until termination of the delivery. We have prepared a set-up which is inexpensive and permits a rapid, aseptic, closed system for injection. This consists of a flash (200cc.) capacity fitted with a two-hole rubber stopper through which a small bore glass tube extends to the bottom of the flask. This tube is bent at right angles after its exit from the stopper and is attached to a 3-way valve by a 12 in. length of intravenous tubing. To the remaining valve outlets are affixed: (1) 20 cc. glass syringe; (2) 3 ft. of special thick walled, small lumen rubber tubing. We have attached a Luer-Loc adapter to this tubing so that the connection to the caudal needle cannot slip. A 19G spinal needle with a long bevel is used. The above are wrapped in towels and autoclaved. There is available a special (BD) malleable needle without a hub which Hingston recommends as an insurance against breakage. In our series we have experienced no such accident with the ordinary spinal needle although some were severely bent upon withdrawal. A 1½% solution of metycaine is prepared by adding 10 cc. of 20% metycaine to 125 cc. of sterile saline in the reservoir flask. The syringe, valve and tubing are connected and all air expelled by filling the system with solution.

The approach to the caudal canal is effected by placing the patient on her side, flexing the back and preparing the sacral area antiseptically after which it is draped with sterile towels. Palpation of the sacro-coccygeal articulation about 1½ in. proximal to the tip of the coccyx reveals two bony prominences, the sacral cornua, between which is a triangular depression, the sacral hiatus. This hiatus is closed by the tough, resilient sacro-coccygeal membrane. A wheal of metycaine is raised intracutaneously over the hiatus and the soft tissues down to the membrane anesthetized by infiltration. The caudal needle is then inserted carefully through the hiatus until the anterior wall of the caudal canal is reached. During this insertion, the needle is at an angle of 45° to the skin. As soon as the membrane is pierced the spinal needle hub is depressed until the shaft is almost parallel to the back, and, with the bevel down, the needle is pushed gently into the canal up to the second

sacral vertebra. Completing this movement with the bevel down minimizes damage to the venous plexus on the floor of the canal. A syringe is attached and aspiration performed to determine whether the needle has pierced the dura or a vein. This test must be carefully performed in every case because if either spinal fluid or blood can be aspirated, suitable correction must be made before proceeding further. (see complications). Assuming that neither of these structures have been penetrated, 10 cc. of metycaine are slowly injected. The solution should enter the canal easily, and the soft tissues over the sacrum watched for swelling indicating that the needle has been inserted too superficially, and is outside the canal. This is the beginner's most common error. If no anesthesia develops within the first five minutes, it may safely be assumed that subdural injection has not occurred; the tubing is connected and the needle covered with a sterile dressing is strapped in place with adhesive. The patient is now turned gently to the supine position and an additional 15 cc. of metycaine slowly injected. She must be warned against making any vigorous unassisted movements lest the indwelling needle be broken or dislodged. Within 15 min. anesthesia will develop, and although uterine contractions can be observed by the attendants, they will be unnoticed by the patient. Frequently anesthesia will be unilateral at the start, and if this occurs the side affected will usually be the one on which the patient lies during the insertion of the needle. For surgical procedures as much as 60 cc. of metycaine can be injected, and upward extension of anesthesia tested until the desired level has been reached. For obstetrics, insensibility to surface stimuli (pin-pricks) should extend up to the umbilicus but not higher. To maintain anesthesia, 20 cc. of solution are injected every 40 minutes in the average patient.

Course of Labor. When anesthesia is developed, the first and second stages of labor are shortened. This is due to a remarkable relaxation of all the soft parts, and to rapid cervical dilatation. Several primaparas delivered within three hours after the onset of labor. The patient is unconscious of any pelvic visceral sensations and the bladder must be emptied when distension occurs. Liquids and a soft diet may be given with advantage during labor. Progress should be checked, but we have found that precipitates are rare. The presenting part usually appears at the introitus, and remains there until delivered by fundal pressure or low forceps. In primaparas we usually perform episiotomy and apply outlet forceps. Both these procedures and the repair are entirely painless. The placenta separates easily and the blood loss is minimal. All the babies were of good color, and even in breech presentations breathed immediately after delivery. We consider placents praevia the only contraindication to this method of anesthesia.

Complications. These are five in number:

1) Massive subarachnoid (spinal) anesthesia is caused by piercing the dura with the caudal needle. As the dura usually terminates at the second sacral vertebra, the needle must never be advanced higher than this level. If the dura is pierced further attempts to produce anesthesia by the caudal route should be discontinued as the puncture does not close immediately.

2) Intravenous injection can be prevented by changing the position of the needle within the canal if blood is observed on aspiration.

3) Vascular collapse which occurred once in our series results from abnormally high anesthesia. This can be prevented by periodically testing the level of anesthesia and maintaining it at the xiphoid (7 Th.) for lower abdominal surgery, and at the umbilicus (10 Th.) for obstetrics. Treatment is with 0_2 inhalations, stimulants and intravenous fluids.

4) Infection of the caudal canal may occur if strict asepsis is not maintained during introduction of the needle or if the site of puncture becomes contaminated by feces. This complication has not been experienced by us to date.

5) Needle breakage within the caudal canal has not occurred because we move the patient carefully and protect the needle at all times during transportation. Those who have been confronted with this accident note that breaks usually take place at the hub-shaft junction allowing easy removal of the projecting fragment. Breakage of the tip deep within the canal would be a more serious happening and would probably require operative removal.

SUMMARY

A brief description of a revolutionary method for completely painless obstetrical delivery is

presented. The application of this method to abdominal surgery is indicated. Caudal anesthesia should be employed only as a hospital procedure and by personnel especially trained in methods of regional anethesia including analeptic and resuscitative measures should untoward symptoms develop.

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ONE INJECTION OF PENICILLIN IS USED TO TREAT GONORRHEA

Army Physicians Report On 175 Patients Given Single Doses Of The Drug In Beeswax And Peanut Oil

A single injection of calcium penicillin in beeswax-peanut oil may now be used successfully in the treatment of gonorrhea, according to the study reported in the June 9 issue of *The Journal of the American Medical Association.* The report, based on 175 cases, was made by Capt. Monroe J. Romansky and Capt. Robert J. Murphy, Medical Corps, Army of the United States, and Technician (3d Grade) George E. Rittman, Medical Department, Army of the United States.

The preparation is made with calcium penicillin — which is a combination of penicillin not so easily dissolved as the more commonly used sodium penicillin — highly refined peanut oil and chemically pure beeswax, all blended together. The purpose of this mixture is to prolong the action of the penicillin, thus increasing the effectiveness of a single injection. After a single injection of 100,000 units of this preparation, penicillin remains in the blood for seven and one-half to ten hours. By contrast, a single injection of 100,000 units of penicillin in a salt solution will produce a high blood level of penicillin in the first hour, but the penicillin entirely disappears from the blood in about four hours and is therefore active for only a short time.

The authors found that 150,000 units in a single dose was most satisfactory. Among 75 patients treated with this dosage there were no failures.

The rapid disappearance of the clinical symptoms of the disease was striking. Eighty-three per cent showed improvement in 12 hours and 95 per cent by the end of 24 hours. The rest improved by the end of three days.

"The injection of the penicillin in beeswax-peanut oil produced no immediate discomfort," the doctors said. "Twenty-four hours following the injection slight soreness was present to pressure, but this was gone within 48 hours." None of the patients showed any reactions to the mixture.

The authors noted that "in view of studies which are now being conducted, single daily injections of penicillin in beeswax-peanut oil have also proved effective in pneumonia, impetigo, staphylococcic infections and other conditions which respond to penicillin in saline solution."

Pulmonary tuberculosis during childhood arises largely from an infection acquired within the household. The source case, the open chronic case of pulmonary tuberculosis whose symptoms so often masquerade under the title of "chronic bronchitis," is a menace to the child and to the community. The detection and control of these chronic carriers of the tubercle bacillus become, with the reduction in the incidence of tuberculous infection, procedures of great importance. We have accepted for too long a period the harmful freedom of these patients, harmful to the individual and to the community. We have accepted with an equanimity which does little credit to our sense of the value of preventive activity the fatalities in childhood tuberculosis and pneumonic adolescent phthisis which have their inception in the contacts which this freedom determines. J. E. Geddes, M.D., NAPT Bull., Apr., 1945.

IMPORTANT

Send changes of address to 30 N. Michigan Ave., Chicago 2, Illinois, enclosing label from a copy showing your old address. Changes received after the 1st of the month will not go into effect until the following month.

Physical Medicine Abstracts

John S. Coulter, M.D.

MYOSITIS IN CHRONIC RHEUMATISM AND CHRONIC GOUT

Frank Hopkins, M.D., Hot Springs, Virginia
In VIRGINIA MEDICAL MONTHLY, 72;6;262
June, 1945

It is disastrous to immobilize muscular inflammation, as it increases blood stasis and therefore results in further exudates and increased pressure. During the very acute stage, the pain will splint the part sufficiently, and as the pain recedes, motion should be re-established as fast as possible. In other words, drainage of the tissues is essential for relief.

Lumbar myositis sometimes produces pain over the abdomen simulating an actute surgical condition. Occasionally, there is an almost constant dull ache over the abdomen.

A very important manifestation is sciatica. The majority of the cases of sciatica come from infiltration of the lumbar and glutcal muscles, but myositis anywhere along the course of the nerve may cause sciatica.

The shoulder muscles are frequently attached, the deltoid being the favorite target; and if the condition is chronic, the fibrous tissues may be involved.

Physiotherapy is the only effective treatment.

REHABILITATION OF THE AMPUTEE

Henry H. Kessler, Captain (MC) U.S.N.R.
In THE UNITED STATES NAVAL MEDICAL BULLETIN, 44;6;1199
June, 1945

The aim of medical and surgical treatment is the relief of symptoms and the restoration of working capacity. In the military service, return to duty is expedited by programs of physical conditioning, convalescent training and occupational therapy.

The first step in the rehabilitation process is that of physical restoration. This is accomplished by means of prosthesis. In the lower extremity the artificial leg serves two functions. It conceals the defect and it replaces the function that is lost. Psychosocial prejudice is thereby minimized while the ability of the amputee to discharge his work responsibilities approaches the normal.

In the case of the upper extremity, concealment of the defect is less adequate. Furthermore the function of the natural hand cannot be reproduced — only imitated. Psychologic prejudice and functional capacity are less adequately met. Nevertheless by means of prosthesis the patient's powers are improved.

The amputee is directed then to the four objectives: Social living, personal hygiene, transportation, and work capacity. These ends are achieved under a program of physical conditioning, occupational therapy, and convalescent training. Before the patient is discharged from this hospital he must satisfactorily pass an achievement test which includes the major elements of the aforementioned four objectives. The hand amputee must learn to dress and undress, tie his shoes, feed himself, lock and unlock a door, handle a key, write, manage a telephone, drive a car. The leg amputee must also pass an achievement test. He must learn how to drive a car, ride a horse, dance, bowl, swim, engage in other sports activities, climb a platform, and descend a ladder or stairs. These are not isolated activities but are carried along with other features of the rehabilitation program.

Though the objectives of personal care, transportation and social living are important, the major factor in the patient's successful rehabilitation will be his economic adjustment on his return to civil life. This phase of his adjustment is, therefore, emphasized in our program.

DEFINITE SURGICAL MANAGEMENT OF AMPUTATIONS

Henry H. Kessler, Captain (MC) U.S.N.R.

In UNITED STATES NAVAL MEDICAL BULLETIN, 44;6;1148
June, 1945

The rehabilitation of the amputee begins with the decision of the surgeon to amputate. The future of the patient will depend in large measure on the site and character of the amputation. The guillotine amputation or the modified flap amputation is only a provisional procedure; the end sought by the final amputation is a stump that will properly carry the patient's weight and permit him to wear a prosthesis with comfort and utility.

The surgeon's work is not completed at the end of the operation. Two further duties remain to be performed. He must prepare the stump to receive the prosthesis and he must teach the patient to use it.

Shrinking. — Preparation of the stump means that the shape of the stump must be changed in order that it may be fitted properly with an artificial limb. The bulbous or edematous stump must be shrunk in order that it may become a narrow cone. This is done by the compression obtained from a tight elastic bandage that has been previously unwound and stretched. Shrinking is also obtained by the wearing of a pylon. Bandaging has the advantage that it can be started early, long before the stump can tolerate the pylon. The bandage is applied under great tension to the end of the stump, otherwise the stump becomes bulbous instead of conical. Bandaging is repeated several times a day, and if rigidly followed sufficient shrinking in from 4 to 6 weeks is obtained so that a permanent prosthesis may be applied. This goal is rarely reached without close scrutiny and supervision. The patient is apt to view the shrinking process with apathy, while the surgeon concentrates on the surgery and not on the aftercare.

Massage. — Massage of the stump is contraindicated. The freshly cut nerves will be too tender to withstand the trauma of manipulation and manual pressure. Physical therapy has no place in the aftercare of amputation stumps except in the management of contractures and in the employment of exercises.

Exercises. — Exercises are rarely necessary in leg amputations. They are required in thigh amputations, especially in short thigh stumps. The loss of the distal attachment of the adductor muscles causes overaction of the abductors. Development of the adductors and extensors of the hip is necessary in order to control the use of the prosthesis. The loss of the knee mechanism puts a double load on the hip extensors, that of extending the hip and the artificial limb.

Definitive surgical management is complete when final amputation has secured a stump of proper length and shape, adequately shrunk with good muscular control to receive and operate a prosthesis efficiently and with comfort.

CAUSALGIA

Frank H. Mayfield, M.D., F.A.C.S., Major, M.C., A.U.S., Cincinnati, Ohio
and John W. Devine, M.D., F.A.C.S., Captain, M.C., A.U.S., Lynchburg, Virginia

In SURGERY, GYNECOLOGY AND OBSTETRICS, 80;6;635
June, 1945

In a study of 15 cases of causalgia the following observations were made:

1. Burning pain is a constant complaint and is usually immediate in onset.

2. The median or sciatic nerve was involved in each instance, and the lesion was incomplete.

3. Certain patients showed vasoconstriction in the causalgic limb; others showed vasodilatation.

4. The trophic changes and response to warm or cold moisture and to hyperthermia varied depending upon the blood flow.

5. Twelve patients were relieved by sympathectomy of the involved limb: 1 was cured by artifiical fever therapy; and 2 recovered spontaneously.

6. Further observation as to the value of fever therapy will be made.

7. Direct surgical attack (neurolysis) upon the injured nerve which was performed on 5 cases, and periarterial sympathectomy at the level of injury, performed in 3, have not been of benefit.

8. Procaine block of the sympathetic chain

affords complete relief temporarily and should be repeated 2 to 3 times, although no case in this series has had any lasting benefit from this procedure.

9. Sympathectomy (preganglionic) gave immediate and lasting relief to 12 patients.

10. The site of injury must be included in the sympathectomy.

11. Sympathectomy should be done early to prevent stiffness of joints due to disuse.

12. The personality changes always present during the painful stages are secondary to the pain. There is no evidence in our cases that there is a predisposing constitutional psychic factor in causalgia.

NON-SPLINTING TREATMENT OF ELBOW JOINT INJURIES

Thomas A. Boutrous, M.D., Surgical Resident, Redford Receiving Hospital
Alexander Blain III, M.D., Fellow in Medicine, Wayne University College of Medicine and
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In THE AMERICAN JOURNAL OF SURGERY, 68;2;213
May, 1945

Conventional methods of treating injuries and fractures about the elbow joint leave much to be desired. These injuries are often followed by undesirable sequelae ranging from various degrees of dysfunction to the dreaded ischemic contractures of Volkman. Downer states that "at the Alexander Blain Hospital conventional splinting of elbow joint fractures has not led to entirely satisfactory results by any means." This is true in the experience of numerous other surgeons.

While the patient was still in the hospital, it was decided to use the non-splinting method of treatment for other fractures about the elbow joint because of the excellent results noted, and because of the dysfunction so often encountered in the past with splinting methods.

In all the following cases it was obvious during the first few days that the patients were timid about active and passive motion. Consequently, especially in the younger age group, close observation was necessary. All the patients were encouraged to take the arm out of the sling four or five times a day and carry out either active and/or passive motion (all positions). The earlier the motion the better and more rapid was the restoration of function.

CARPAL BONE INJURIES

John D. Sherrill, M.D., Birmingham, Alabama

In SOUTHERN MEDICAL JOURNAL, 38;5;312
May, 1945

(1) Wrist sprain should not be diagnosed until the x-rays are negative.

(2) If pain persists, films should be made at intervals even though the original film was negative.

(3) In fractures of the lower end of the radius or ulna, look for associated carpal injuries.

(4) Conservative treatment of fresh fractures of the scaphoid and closed reduction of dislocated semilunars is the treatment of choice.

(5) Conservative treatment is advisable in non-unions of the scaphoid if there is reasonably good wrist function.

(6) Excision of one or more carpels is advocated in the treatment of comminuted fractures, dislocations of the semilunar or mediocarpal joint, if conservative therapy fails.

CORONARY OCCLUSION AFTER FEVER THERAPY

In THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 128;5;386
June 2, 1945

Harvey and Billings used fever therapy in the treatment of 85 young men with chronic gonococcic urethritis resistant to sulfonamide therapy. Three patients, aged 24, 19, and 25 respectively developed electrocardiographic changes typical of occlusion of a coronary artery after fever therapy. In 1 case there were never any symptoms referable to the heart, and in the other 2 they were relatively mild and the illness was never serious. Electrocardiograms in each case showed progressive changes similar to those which occur with occlusion of the anterior descending branch of the left coronary artery. In 2 cases definite T wave changes were still present eight and ten weeks after the onset. In the third case a record made fifteen weeks after the therapeutic hyperpyrexia revealed normal T waves. Subsequently, in 15 cases, records were made routinely before and for three days after therapeutic hyperpyrexia. In 2 of these the electrocardiograms showed a coronary type of ST segment and T wave change within twenty-

four hours, which persisted for several days but then reverted to normal. Neither patient had complaints referable to the cardiovascular system. In several others a transient cardiac arrhythmia was observed in addition to minor changes in the ST segments and T waves.

METRAZOL AND ELECTRIC SHOCK IN PSYCHOSES

In THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 128;5;388

June 2, 1945

The Ziskinds present a comparison of treated and untreated patients with affective psychoses who were seen in private practice between 1938 and 1943. Of 88 patients treated the first 58 received metrazol and the other 30 were given electric shock therapy. The untreated control group included 109 patients, of whom 43 refused convulsive therapy, 50 had symptoms which were too mild to warrant this treatment and 16 had physical disease which contraindicated the method. The follow-up results were full remission in 90 per cent of the treated patients and in 75 per cent of the untreated patients. In the untreated patients there were nine deaths from suicide and four deaths from exhaustion, as compared with one death from suicide in the series of treated patients.

CORRECTIVE CAST FOR TREATMENT OF LOW BACK PAIN

Emil D. W. Hauser, M.D., Chicago

In THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 128;2;93

May 12, 1945

Low back pain, in most cases, is due to a strain which causes an inflammation in the region of the lumbosacral and sacroiliac articulations. Strain is the result of an imbalance between the capacity of the structures of the back and the physiologic demands made on them. This imbalance is called a functional decompensation. A decompensation of the back gives rise to certain symptoms and findings.

The treatment of low back pain, therefore, consists in correction of the deformity, relief of the strain at the sacroiliac and lumbosacral joints and elimination of the decompensation of the back. This is accomplished by means of a so-called active cast. An active cast is one which is applied with the body in a position such that the natural forces of the body will act against the cast. In this way the cast has the effect of exerting a corrective force.

The cast exerts forces to correct the deformity of the back and at the same time relieves the strain on the joint so that the inflammation can subside. Since the trunk is extended and the body is higher than before the application of the cast, more work is required to hold the upright position. This brings about an increase in the demand on the muscles, which acts to strengthen these structures. This increase in strength is further abetted by means of graduated exercises, alternated with periodic rests to prevent muscular strain.

This treatment by active cast has been applied in 2,626 cases. Excellent results were obtained in 35.6 per cent of the cases.

THE MANAGEMENT OF OSTEO-ARTHRITIS

A. R. Neligan, M.D.

In PROCEEDINGS OF THE ROYAL SOCIETY OF MEDICINE, 38; 5; 210

March, 1945

Indications for management. — The chief indications in the management of an established case of osteo-arthritis are: (1) To secure the co-operation of the patient. (2) To ensure the best possible environment for him. (3) To remove aetiological factors or, at least, lessen their effects. (4) To maintain function. (5) To relieve pain and improve the condition of the joint.

Rest periods are the single essential part of management in osteo-arthritis.

Activity. — Most osteo-arthritics are cheery, energetic folk, used to working hard and playing hard, so it is wise on general grounds to allow them as much activity as may be judged prudent.

Weight reduction. — The diet of the elderly should suit digestion and be well balanced. I think that is about all there is to say about the osteo-arthritic unless he is overweight, as he, or rather she, very often is. Then drastic reduction is an excellent way of sparing spine and legs and may give dramatic all-round improvement.

Maintenance of function. — "Management" of general activity helps to preserve joint function in damaged joints, but something more is

needed, namely, active stretching of the joint and active training of special muscle groups.

Treatment of the joints aims at relieving pain and improving the circulation, deficiency in which seems to be the one common factor in chronic rheumatic conditions; and, if arteriosclerosis is by no means regularly found in osteoarthritic joints, their owners are at an age when it is common.

Expert physical treatment gives opportunities for review.

The drawbacks of expert treatment may, however, from the point of view of many patients, be very real. It is a question, too, if the simple ways of applying heat mentioned are much less effective than our more complicated methods, except, perhaps, diathermy in the case of the hip and some forms of bath treatment including the therapeutic pool, though, even here, domestic and local swimming baths may be turned to account.

Massage and exercises for the associated muscles, as well as general exercise, also improve the joint circulation and so should attention to varicose veins in the case of the lower limbs. However, fibrositis of muscles and joint capsules are the chief indications for massage in osteoarthritis.

KNEE INJURIES IN SOLDIERS

L. H. Wilkinson, M.B., Edin., Major RAMC
H. A. Burt, M.C., Camb., MCRP, Captain RAMC
Specialists in Physical Medicine

In THE LANCET, 1;22;685
June 2, 1945

Treatment

Tender sites. — As a rule, tenderness of the semimembranosus insertion responds satisfactorily to physical treatment. Heat and friction on alternate days seem all that is required. After four treatments a noticeable improvement is apparent, and the patient often volunteers that he is better able to straighten his affected knee.

Physical methods are disappointing with the other sites of tenderness. An occasional exception is histamine or iodine ionisation in cases of painful ligamentum patellae.

Effusion. — Effusion which develops after exercise can often be prevented if a compression bandage is applied directly after such exercise. The bandage should be retained until the next morning and reapplied after further similar activity.

Quadriceps insufficiency. — By the time the convalescent stage has been reached non-weight-bearing remedial exercises are the most useful means of treatment. Weights and pulleys are now popular, but as usually employed, with the patient sitting on a bench, they are unsatisfactory, as the exercise is often stopped with the knee short of full extension. The modification advocated by Duthie and Macleod (1943), with the patient lying prone, is more satisfactory. Static contractions of the quadriceps are often poorly carried out with a tender ligamentum patellae, and the vastus internus, which is almost invariably the most wasted of the quadriceps group, cannot be correctly exercised when there is limitation of extension of the knee (Nicoll 1943). On rare occasions efforts at obtaining full extension are carried too far, and hyperextension is demonstrable, but this can sometimes be corrected by re-education of the hamstrings.

FUNCTIONAL TREATMENT OF FRACTURES AND OTHER INJURIES

Edward Harlan Wilson, M.D.

In ARCHIVES OF PHYSICAL MEDICINE
26;6;352
June, 1945

Fractures close to or involving a joint will continue to require splinting. Open reduction, when feasible, will often permit earlier motion and return of function. Early motion after manipulative fractures near the wrist and ankle is to be decried; it merely leads to prolongation of the recovery period. Open reduction of all fractures is increasing.

Physical therapy has a very important place in rehabilitation. It is largely a psychotherapeutic method, in that the patient is educated to begin to use his muscles in the region of a fracture and is taught how to do so without pain or injury to himself. Hypertrophy of the wasted muscle is encouraged. Its use, especially early in fracture treatment, should be limited to assisted active motion with the patient's sense of pain as the guide to the limit of motion. When the patient has definitely learned to move his limb and to place weight on it, physical therapy has accomplished all that it can and its further use will tend to retard the patient's progress because his condition combines local weakness and stiff-

ness with general weakness due to his prolonged period of rest. The experience of the British in this war in the use of rehabilitation camps, and more recently the experience of our own Army, has emphasized the importance of prolonged and extremely active physical exercise. This has been obtained by early marching drill, even for men in casts, with the prompt addition of graduated games such as volley ball and tennis, sawing lumber, swimming, etc., until the patient is active about six hours a day, which is the limit of his endurance. By the use of these methods tremendous progress has been made in the rehabilitation not only of injured limbs but of men themselves. To consolidate these gains for civilian life it will now become necessary to develop rehabilitation centers in industrial cities where not only physical therapy and occupational therapy are furnished but also exercise which exploits the patient's liking for competition and fun.

PERIPHERAL VASCULAR DISEASE

Geza de Takats, M.D., Chicago, Illinois

In THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY, 44;5;481

May, 1945

Mechanical means of increasing the vascular bed are many; the Buerger-Allen exercises alternately fill and empty the venocapillary bed; however, they are not apt to be carried out for a long enough period to do it consistently. The suction pressure apparatus has given a great impetus to all mechanical forms of vascular exercise, but it is an expensive form of treatment which we have substituted with intermittent venous hyperemia. This form of treatment can be carried out at home with an ordinary blood-pressure apparatus, with a specially built leather cuff pumped by hand or with an automatic device operated by electricity, which the patient applies from two to twelve hours daily depending on the severity of his circulatory deficiency. The pressures and the time of constriction and release must be determined individually for each patient and so selected that during constriction a marked filling of the veins and rubor of the toes occur, whereas during release the limb takes on its normal color and the veins collapse. Many hundreds of our patients have used such an apparatus for months and years and have increased their walking ability to a great extent.

Another device which has given our patients decided benefit is the oscillating bed. This supplies the patient with a Buerger-Allen exercise, without any effort on his part and for six to eight hours a day continuously.

THE MANAGEMENT OF RHEUMATOID ARTHRITIS

Francis Bach, M.D.

In PROCEEDINGS OF THE ROYAL SOCIETY OF MEDICINE, 38;5;207

March, 1945

The four main clinical and pathological forms of rheumatism are rheumatic fever, the rheumatoid type of arthritis, the osteo-arthritic type and non-articular rheumatism or fibrositis.

Although these forms of rheumatism are differentiated it is the sick man and not the disease process that we are called upon to treat. People react in different ways to similar extraneous stimuli.

The successful treatment of the early and active phases of rheumatoid arthritis is dependent on close co-operation between the patient and the medical staff. The latter may consist of a team as in the Rheumatic Unit or of one man as must often happen in general practice. The aim of treatment is to help the patient to increase his or her resistance by altering some of the constitutional and environmental pictures which cause ill-health and by this means to modify the clinical picture of the disease. Psychological, medical, physical and sociological measures play an important part in this achievement.

COLLES' FRACTURES

J. Warren White, M.D., Greenville, South Carolina

In SOUTHERN MEDICAL JOURNAL, 38;6;417

June, 1945

(1) Do not attempt reduction without x-rays.
(2) Do not attempt reduction without an anaesthetic.
(3) Do not stop short of anatomical reduction.
(4) Do not use splints if plaster is available.
(5) Do not take the cast off too soon.
(6) Do not forget to tell the patient to move his fingers.
(7) Do not use too strenuous physical therapy actively or passively.
(8) Do not resort to subsequent surgery in older people.

Industrial Health

Committee On Industrial Health — Jos. H. Chivers, Chm., 836 S. Michigan Ave., Chicago 5, Frank P. Hammond, H. A. Vonachen, R. I. Barickman, C. O. Sappington, Milton H. Kronenberg.

The return of service men to civilian employment will frequently present to the physician in industry problems and inquiries relating to disability and disease acquired in military service.

INFORMATION REGARDING THE EFFECT OF MALARIAL ATTACKS ON THE HEALTH OF THE INDIVIDUAL*

A great deal of misinformation and misunderstanding exists concerning the effect of repeated relapses of benign tertian malaria on an individual's general health. Anxiety caused by such ignorance in itself may seriously impair medical fitness. For this reason, it is important that accurate information based on latest available data be thoroughly disseminated among all troops who have been, or may be, exposed to malaria.

Under current War Department directives all commanders are responsible for the initiation and enforcement of the measures necessary to control malaria within their units and unit areas. It is their duty, moreover, to see that unit medical officers thoroughly instruct officers and enlisted men in methods of prevention and suppression of malaria. It is also extremely important that unit medical officers make available to line officers and enlisted men reliable information concerning the significance of malarial attacks, especially relapses, from the point of view of their effect on the individual's health. In particular, medical officers in charge of patients should explain the subject thoroughly to their patients who have malaria.

Adequate measures prevent infection with malaria, except in a negligible number of individuals. The importance of carrying out these measures is stressed. However, at the beginning of combat operations in highly malarious areas, the institution of adequate control measures may be impossible and a certain number of individuals engaged may become infected with malaria. Moreover, there are a number of individuals in the Army already infected with malaria which has not yet run its course. Experience shows that under appropriate management nearly all such individuals can be maintained in the state of health requisite for the performance of the most exacting duties of military service.

Benign tertian malaria, due to *Plasmodium vivax,* is the only type of malaria with military significance which commonly causes repeated attacks or relapses. Available treatment does not prevent relapses of malaria due to *P. vivax* after the treatment is discontinued. It is well known, however, that relapses of all types of malaria can be avoided, or suppressed so that no clinical activity of the disease can be detected, by the continued taking of an antimalarial drug such as atabrine. The use of atabrine actually cures the form of the disease known as malignant tertian malaria caused by *Plasmodium falciparum,* with the result that relapses rarely occur.

When attacks of malaria do occur, if medical treatment is instituted promptly and adequately, the symptoms are relieved with great rapidity and all progress of the disease is quickly suppressed. In most cases, symptoms are relieved within forty-eight hours. As a result of prompt

From the Medical Consultants Division, Surgeon General's Office.

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and efficient action, attacks of malaria by themselves cause only brief incapacitation and result in no permanent damage to the body. It is of interest to note that, because of advances in knowledge concerning treatment and handling of individuals with relapses of malaria, the number of days lost in hospital has been reduced from fourteen or fifteen days to about seven. Deaths due to malaria in Army personnel in the whole period since the beginning of the war have been rare and nearly always associated with other diseases in addition to malaria, and with circumstances which caused delayed or inadequate treatment. Any impairment of health which does arise from attacks of malaria is relieved by simple measures in a relatively short time. Even in individuals in whom a large number of relapses have occurred, the cumulative effect on the body has been slight or nil. In general, the severity of the attacks decreases and the effectiveness of treatment increases as time goes on.

Worry and anxiety over the significance of infection with malaria may do more harm than the properly treated disease itself. For this reason, an understanding of malarial relapses and of their lack of serious import for the patient's general health contributes enormously to improvement in the individual's well-being and fitness.

Relapses of malaria may be precipitated, in infected individuals who are not taking adequate suppressive medication, by many forms of activity. It has been demonstrated by exhaustive studies, however, that individuals who are protected by the use of regular, adequate, suppressive medication are not subject to relapses of malaria even though undertaking strenuous activities. Comparison of Army experience in northern and southern sections of the United States shows there is no evidence for the popular belief that climate has any lasting effect on malarial relapses.

Many soldiers do not realize that the standard Army treatment for malaria is the best available. It has the backing of Army experience all over the world and, in addition, of the most experienced civilian authorities in the country. The Board for the Coordination of Malarial Studies, which regularly advises the Medical Department, constantly collects from all over the world information about the treatment of malaria. There is no reason to believe that any particular individual or institution possesses a private or secret cure for relapsing malaria. Numerous drugs and other agents are advanced from time to time as cures for malaria which are, for the most part, useless. Often a method is considered a cure merely because the patient is not followed long enough for a relapse to be observed. When any new method offers promise of being good, it is thoroughly investigated.

There is a great deal of misunderstanding concerning the yellow color of the skin associated with the use of atabrine. This color is not due to jaundice or to any other derangement of body functions. It is due to the fact that atabrine is yellow and is deposited in the skin. The yellowness disappears spontaneously after use of the drug is discontinued.

Unless properly instructed about the natural course of benign tertian malaria, soldiers are inclined to think that once infected they will have malarial attacks for the rest of their lives. It should be emphasized that this is not true. Malarial relapses do not continue to occur indefinitely, even though suppressive medication is discontinued. Some individuals have only two, three, or four attacks. In general, relapses tend to be successively less severe and to occur after increasingly long intervals. Only rarely do individuals have relapses after two or three years have elapsed from the time of their last infection.

Soldiers should be instructed that, though infected with malaria, they should not consider themselves a menace to their fellows, their families, or their communities, provided they promptly obtain medical treatment if any symptoms occur. Malaria can be spread only by anopheline mosquitoes, and, in general, mosquito control measures are adequate to prevent its spread.

In the final analysis, relapsing malaria is not a disease greatly to be dreaded by the individual, in comparison with other dangers to which the soldier is exposed. Medical officers should see that men under their care, especially those with malaria, acquire a satisfactory understanding of pertinent facts about the disease.

News of the State

PERSONALS · COMING EVENTS · MARRIAGES · DEATHS

★ War Service Activities ★

COOK COUNTY

Captain A. Kushner who formerly practiced at 3738 Irving Park Boulevard, Chicago, received the Purple Heart in November and has just been awarded the Bronze Star for work done while under enemy artillery and mortar fire and for the help he has given as a linguist and for work done in his own unit in a professional capacity. He acted as Russian interpreter on the Russian-German front.

Recently promoted from major to lieutenant colonel in the army medical corps was Benjamin H. Kesert, Chief of the neurological service at Hines Hospital. He maintained offices at 30 North Michigan Avenue, Chicago, before entering the army as a major 16 months ago.

Lt. Col. Jack Segal of the medical corps has been named executive officer of the army's Gardiner General Hospital, Chicago, by Col. John R. Hall, commanding officer. Col. Segal returned recently from Germany where he commanded the 47th field hospital, which landed in Normandy last summer and followed the 1st Army through all of its campaigns.

The Chicago Tribune carried the following story about Lt. Comdr. W. Walter Sittler of Chicago on July 15:

Americans came to Okinawa expecting a hot, stinking climate, hordes of snakes, flies, and mosquitoes, and many deadly diseases. They found cool nights, not too uncomfortable days, almost no snakes, and no more insects than they had battled elsewhere.

"From the standpoint of climate and health, this is the best island we have taken in the Pacific," said Lt. Comdr. W. Walter Sittler, 10929 Longwood Dr., Chicago, head of the department of medicine at the military government hospital.

Lieut. Col. Fred E. Ball, formerly of Chicago, has been appointed District Consultant for Internal Medicine to the Air Surgeon. Now chief of Medical Services at the AAF Regional and Convalescent Hospital, Miami District, Colonel Ball is consultant for the Southeast District, which comprises the states of Tennessee, Mississippi, Alabama, South Carolina, Georgia and Florida. Dr. Ball graduated from the University of Minnesota Medical School, Minneapolis, in 1923 and entered the service in 1942.

Captain A. A. Wolf, 304th Station Hospital, has been promoted to Major and has been issued a new A.P.O. His present address is: 304th Station Hospital, A.P.O. 513, c/o Postmaster, New York.

Captain Edwin C. Reynolds, Sr. of 4423 Sheridan Road, Chicago, has returned after two years of service with the Medical Corps in New Guinea and the Philippines.

Lt. Comdr. Andrew Toman, former medical superintendent of the Bridewell Hospital, Chicago, is home on leave after serving off Iwo and Okinawa Islands on the U.S.S. Mifflin, an assault personnel auxiliary ship which carried fighting men to the battle and then, converted into a hospital ship, stood by while small boats brought many back as casualties.

Captain John A. Guerrieri, who had an office at 7209 West Grand Avenue, Chicago, has written the Editor: "Your Journal is well appreciated as well as well read. Asking you to forward it to the above address." Captain Guerriere was recently awarded the Bronze Star for meritorious service in support of combat operations throughout the European campaign. His complete term of service has been with the Third Armored Division (also called the Spearhead Division). He is also the recipient of the Purple

Heart, for wounds received in action against the enemy. He entered the service on September 29, 1942.

Captain Paolo Ravenna of Chicago has sent the following message to the Editor of the Journal: "I enjoy very much receiving the Journal regularly as it keeps me up to date on some of the doctors' problems on the home front, with which I have lost contact so long ago. My campaign from Normandy to Czechoslovakia with the 103rd Evacuation Hospital is now over and we don't know what is presently in store for us."

DU PAGE COUNTY

Lt. Comdr. Alvin L. Mathis who practiced in Elmhurst, was presented with the Silver Star in a ceremony May 26th at Camp Pendleton, California. He has served with the First Marine Division in the Pacific, and was cited for intrepedity and initiative in administering to, and evacuating wounded from beyond the front lines on Peleliu last September 17th.

HENRY COUNTY

Captain Nolan G. Montgomery, former Kewanee physician and surgeon, is stationed at Crile General Hospital, Cleveland, Ohio, where he is in the orthopedic section. Ninety-seven per cent of the orthopedic section at the Hospital are overseas veterans.

KANE COUNTY

Major James R. Tobin, Army medical officer who has returned from China after acting as chief surgeon in a U. S. Hospital has arrived in Elgin on a thirty-day leave.

Captain E. M. Thomas of Aurora, is chief of surgery at the 7th Convalescent Hospital, Cologne, Germany.

LA SALLE COUNTY

Lt. Col. Timothy Mullen of Seneca has been awarded the Bronze Star for meritorious service in support of military operations against the enemy in northern Luzon and the Philippines from February 15, 1945 to May 10, 1945.

LAWRENCE COUNTY

Edward A. Fahnestock of Bridgeport, recently received a promotion to the rank of Major in the Army Air Corps at his base in Oahu where he has charge of the large evacuation station on that island. He is commanding officer of the 812th Medical Air Evacuation Squadron.

MADISON COUNTY

Major E. R. Quinn, army medical corps, formerly of East Alton and Wood River, has returned to the United States for a thirty-day leave. He has served in the European theater for almost two years as regimental surgeon for the 356th Engineers Regiment. He was stationed first in England, then later sent to France and was in Germany when hostilities ceased.

McLEAN COUNTY

McLean County Medical Society has 88 members, 39 of whom are in military service, and two of whom have given the supreme sacrifice. The officers of the Society state that according to membership, McLean County Medical Society has a larger per cent of doctors in service than any other in the state.

PERRY COUNTY

Lt. Comdr. John W. Stevens, former practicing physician in DuQuoin, has been awarded the Navy and Marine Corps Medal as of June 6th, 1945, for heroism as battalion surgeon during an aerial bombardment off Roi and Namur in February, 1944. The presentation was made in the presence of the entire Georgia Pre-Flight School medical staff, Athens, Georgia, where the recipient is stationed as assistant medical officer. Captain Charles C. Yanquell, senior medical officer, read the citation signed by Fleet Admiral Chester W. Nimitz, and pinned the decoration on Lt. Comdr. Stevens.

ROCK ISLAND COUNTY

Captain Samuel P. Durr, of Rock Island, is at his home, after completing 26½ months overseas duty. He served in North Africa, Corsica, Sicily and France and is holder of the Soldier's medal for aiding in the rescue of injured persons from a burning ammunition barge in Sicily, October 11, 1943.

SANGAMON COUNTY

A flight surgeon with the 46th bomb group, Captain Henry S. Dickerman, Jr., of Springfield is now home on a thirty-day leave. He was overseas 28 months and has received six battle stars for Sicily, Salerno, Rome, southern France, Arno River and the Apennines. He wears the Presidential Unit Citation, the European Theatre Ribbon and the American Defense Bar.

General

ADAMS COUNTY

Miss Myrtle McAhren, Superintendent of Blessing Hospital, Quincy, was elected president of the Illinois Hospital Association at a board meeting held in Chicago on July 14. Stuart K. Hummel, first vice-president of Silver Cross Hospital, Joliet, was named first vice-president of the Association to succeed Miss McAhren.

CHAMPAIGN COUNTY

Maude Lee Etheredge, for 22 years head of the women's division of health service and professor of hygiene at the University of Illinois, recently announced her resignation which is to become effective September 1. Doctor Etheredge received her M.D. degree from Loyola and a doctor of public health degree from the University of Pennsylvania. She did work at Johns Hopkins and Columbia Universities and the University of Michigan.

J. Nelson Ewbank, a native of Farmer City, formerly superintendent and medical director of the Sand Beach Sanatorium at Lake Park, Minnesota, on July 1st became medical director of Outlook Sanatorium, Champaign County's tuberculosis hospital. Doctor A. T. Cole, former medical director, has gone to Tampa, Florida, to become superintendent and medical director of a tuberculosis sanitorium.

CLAY COUNTY

The Clay County Medical Society and the Illinois State Medical Society paid tribute to Doctor N. W. Bowman of Flora at a dinner meeting held on July 12th in Flora. John Shore of Sailor Springs was Toastmaster and the presentation of the 50-year pin and framed certificate were presented to Doctor Bowman by Doctor Andy Hall of Mt. Vernon. The Presbyterian Church, where the dinner was held, and of which Doctor Bowman is a member, presented him with a handsome billfold.

Meyer H. Parker, formerly of Flora, has opened offices at Louisville following his discharge from the Army. Doctor Parker was a Captain in the Medical Corps and returned a few months ago after serving with the 27th Division.

COOK COUNTY

Conrad Sommer has resigned as a deputy director of mental hygiene of the State Department of Public Welfare to join the staff of Washington University, St. Louis, Missouri. He will take up his work at the start of the fall term. Doctor Sommer graduated from the University of Illinois School of Medicine and served his internship at Orange, New Jersey.

M. A. Perlstein of Chicago was invited to speak before the Illini Chapter of the International Council for Exceptional Children at a dinner given in Urbana, July 11.

Lawrence J. Linck, executive director of the Illinois commission for handicapped children since 1940 and director of the division of services for crippled children at the University of Illinois since 1941, has been appointed executive director of the National Society for Crippled Children and Adults, Inc. He will assume his new post September 1st. He will continue to serve as lecturer in public administration at the University of Illinois College of Medicine and as administrative consultant to the division of services for crippled children.

The Museum of Science and Industry in cooperation with the Chicago Medical Society and the Educational Committee is presenting a summer lecture series on Wednesday evenings at 8:00 in the air-cooled auditorium of the Museum, 57th Street at the Lake, Jackson Park, Chicago. The following programs have been scheduled:

July 18 — Care of the Skin and Cosmetics — Harry M. Hedge, M.D.

July 25 — High Blood Pressure — Chauncey C. Maher, M.D.

August 1 — Our Walk Through Life — Emil D. Hauser, M.D.

August 8 — Hay Fever and Prevention of Asthma — Leon Unger, M.D.

August 15 — Infantile Paralysis — Edward A. Piszczek, M.D.

August 22 — Getting Along With Your Children — H. W. Elghammer, M.D.

Itinerant pigeons in Chicago will be tested in the city laboratories of the state department of health to determine if they are carriers of a virus type pneumonia, the Chicago Sun reported June 21. Similar tests made at the University of California on pigeons taken from the streets of Philadelphia resulted June 20 in an order by the Philadelphia Department of Health for extermination of the pigeons in the squares and parks, the Sun stated. The tests disclosed that 45 per cent of the birds carried a virus which is said to resemble psittacosis. Two tests will be made to identify the virus —one a test of the pigeon serum for the presence of antibodies, and the other to isolate the virus in the pigeon tissue. Recent pigeon tests made in Detroit revealed antibodies in the pigeon serum.

Clarence L. Wheaton, Vice-President of the Tuberculosis Institute of Chicago and Cook County, has been elected to represent that Institute before the National Tuberculosis Association.

George A. Klein, medical examiner in Chicago for the 7th regional headquarters of the United States civil service commission, has been transferred to Los Angeles, California. He has been a resident of Chicago for 35 years and formerly was with the state board of health and the Chicago health department.

EDWARDS COUNTY

H. L. Schaefer of West Salem has been given a life time pass good on all lines for 40 years of faithful service as physician and surgeon for the Illinois Central Railroad.

MARSHALL COUNTY

After two and one-half years in the army, two of which were spent overseas, Captain B. I. Ryder, has retired from active duty and has returned to his practice in Henry. He served in England, Belgium, France and Germany as a battalion surgeon. Since his return from France, he has been a convalescent patient at Vaughn General Hospital at Hines.

PEORIA

George P. Gannon, U. S. Public Health Service, recently state venereal disease control officer in Denver, has been appointed temporary health commissioner of Peoria. He will continue in this position until the return of Doctor Sumner M. Miller who is away because of ill health. Doctor John L. Lincoln, U. S. Public Health Service, held the position until the appointment of Doctor Gannon.

ST. CLAIR COUNTY

Edmond Bechtold of Belleville has been reappointed to a three-year term as a member of the board of directors of Pleasant View Sanatorium, the St. Clair County Tuberculosis Hospital.

Roland R. Cross, Director of the Illinois Department of Public Health, announces the establishment of a tumor diagnostic service at the Christian Welfare Hospital in East St. Louis to be conducted under the auspices of the State Health Department, through its Division of Cancer Control. This facility will provide a convenient consultation service for the practicing physicians of this area in the care of their suspected tumor cases. The program has been developed in cooperation with the St. Clair County Medical Society.

SANGAMON COUNTY

Dr. Herbert B. Henkel, Jr., of Springfield, son of Doctor and Mrs. H. B. Henkel, who recently completed his internship at St. John's Hospital, St. Louis, has been awarded a fellowship at the Mayo Clinic at Rochester, Minnesota.

UNION COUNTY

The Anna State Hospital complimented Angelina G. Hamilton, psychiatrist, with a surprise tea, May 12th in recognition of her seventy-third birthday and the completion of thirty-eight years of continuous State Service on the Medical Staff. Dr. Hamilton's friends from Anna, Jonesboro and other nearby cities and the Anna State Hospital, called to extend their congratulations. She was the recipient of many lovely gifts, among them, a strand of pearls from the Medical Staff of the Anna State Hospital.

WINNEBAGO COUNTY

The Division of Services for Crippled Children of the University of Illinois conducted an orthopedic clinic at St. Anthony's hospital, Rockford, on July 19th. Cooperating in the conduct of the clinic was the Winnebago County Medical Society and the Rockford Visiting Nurse Association. Rudolph J. Mroz of Rockford made the medical examinations.

MARRIAGES

Lorin L. Fowler, Marion, Ill., to Mrs. Lulu Caplinger of Downey, Calif., May 4.

Aldona A. Juska, Oak Park, Ill., to Max R. Kennedy, D.D.S., in Nome, Alaska, April 19.

John T. Sullivan, Jr. to Dr. Tullia D. Tesauro, both of Chicago, May 30.

Major Malcolm C. Todd, Cairo, to Miss Ruth Schlake at Westminster, London.

DEATHS

Charles Melville Bacon, Chicago; Rush Medical College, 1914. Staff member of Presbyterian Hospital; was medical director of Marshall Field & Company for many years, taught medicine at Rush and was associated in clinical work at the University of Illinois College of Medicine. Died of a heart attack July 12th at the age of 58.

Frederick Emil Barthes, La Grange Park, Ill.; Loyola University School of Medicine, 1942; began active duty as first lieutenant in the medical corps Aug. 8, 1942; promoted to captain; killed in action in Belgium, Dec. 18, 1944, aged 36.

Henry M. Beckwith, Joliet; Hahnemann Medical College and Hospital, 1897. Died in a hospital at Poplar Bluff, Mo., of injuries suffered when struck by an automobile, June 27, aged 78.

Fidelio Fletcher Brown, Chicago; National Medical College, Chicago, 1896; Dunham Medical College, Chicago, 1900; also a dentist; life member of the Illinois Dental Association and member of the American Dental Association; died May 28, aged 75, of cardiac degeneration and Parkinson's disease.

Maurice D. Chernoff, Chicago; Chicago Medical School, 1926. Died of a cerebral hemorrhage in Garfield Park Hospital on July 13th at the age of 43.

Louise Lockwood Culver, Sandwich; University of Illinois College of Medicine, 1901. In 1937, she was made an honorary member of DeKalb County Medical Society and in 1942, was named an emeritus member

of the Illinois State Medical Society. Died July 14th at the age of 75.

Frances Dickinson, Chicago; Woman's Medical College, Chicago, 1884. Served as dean and president of the Harvey Medical College. Died May 19th, aged 89.

Charles John Drueck, Sr., Chicago; Northwestern University Medical School, 1896. Was editor and publisher of Proctology; on the surgical staff of the Illinois Masonic Hospital. Died June 30, aged 72.

Michael A. Galgano, Chicago; University of Illinois College of Medicine, 1914. Had practiced medicine and surgery for 30 years. Was found dead in his automobile from a heart attack July 14th. He was 54.

Joseph Frank Hubert, Chicago; Bennett Medical College, 1883. Practiced medicine in Ashkum, Illinois, when a young man. Died in his home at the age of 86 on June 22nd.

Thomas Lee Hutton, Hartsburg; Barnes Medical College, St. Louis, Mo., 1908. Had practiced medicine at Hartsburg for 24 years. Died July 20th at the age of 66.

John E. Koons, Chicago; Jenner Medical College, 1905. Formerly professor of ophthalmology, rhinology and otolaryngology at Chicago Eye, Ear, Nose and Throat College. Assistant professor of clinical otolaryngology at Chicago Medical School. Died in July at the age of 69.

Ferdinand C. McCormick, Normal; Northwestern University Medical School, 1899. Died in July at the age of 70.

Benjamin Lewis Rawlins, retired, Hinsdale; University of Pennsylvania School of Medicine, 1889. Former Hinsdale Health Commissioner. Died July 11th, aged 78.

Sidney M. Roberts, Chicago; Loyola University School of Medicine, 1917. Had practiced medicine on Chicago's north side for 25 years, served with the Civilian Conservation Corps and the Selective Service induction board and was a member of the adjudication board of the Veterans Administration at Hines Hospital. Died, aged 57, at Sparta, Wis., July 16th.

George Rubin, retired, Chicago; University of Illinois College of Medicine, 1898. Post-graduate work in Paris and Berlin; was captain in the army medical corps in World War I; formerly a fellow in pathology at Rush Medical College. Died, aged 68, July 15th.

Rudolph George Schroth, Chicago; National Medical University, Chicago, 1904. Practiced medicine in Chicago for 40 years. Died July 17th at the age of 68.

Henry Steible, Chicago; Jenner Medical College, 1900. Formerly Chicago police surgeon. Died in Hammond, Indiana, July 14th, aged 69.

IS IMMUNITY TO PNEUMONIA POSSIBLE?

Can a person develop an immunity to pneumonia? The answer, which appears in the July 7 issue of *The Journal of the American Medical Association,* is that apparent specific immunity does occur after an attack of lobar pneumonia, but it is of brief duration. Medical reports cite instances in which two attacks caused by pneumonia of the same type occurred within a year. Consequently, recovery from an attack of pneumonia may not necessarily insure immunity against a later attack.

CONTROL OF RABIES IN DOGS

Rabies in dogs can be controlled by quarantine and by immunization against the disease through a single injection of the vaccine, *The Journal of the American Medical Association* for April 28 reports. *The Journal* says that experiments now have established that the single injection of an antirabic vaccine produces a high degree of immunity in the dog.

"An effective program to control canine rabies," *The Journal* states, "must include quarantine to prevent the spread of the virus by stray dogs and dog traffic. There seems to be no question that canine rabies can be controlled by means of quarantine and vaccination. . . ."

I am strongly of the belief that the rapid decline in tuberculosis in this country during the last two decades has been due in no small part to the control of bovine tuberculosis. I believe this applies to the mortality, morbidity, and certainly to the infection attack rate. The decrease in the incidence of tuberculin reactors among children has been phenomenal; in fact, we now have whole counties where not more than five to eight per cent of the senior students in high school react to the tuberculin test. J. A. Myers, M.D., Am. Rev. of Tuber., Dec., 1944.

The rheumatic fever rate will surely decrease substantially and effectively if a community can manage to provide better socio-economic conditions for its citizens through improved housing and an opportunity for more healthful outdoor activities; less crowding and an intelligent consciousness of good nutrition; good public health control of communicable disease, particularly streptococcal respiratory colds and sore throats, with facilities for careful examination of children suspected of having rheumatic fever. This has been accomplished to a great degree in the case of tuberculosis control, and a more thorough application of these principles will reduce further the tuberculosis rate as well as the rheumatic fever rate. Hugh McCulloch, M.D., Minn. Med., Dec., 1944.

P. R. N.

The Jocular Jingles of C. G. F.

by

Charles G. Farnum M. D.
Peoria, Ill.

THE BROWN GALLON BOTTLE

I sadly recall all the erstwhile diseases
And surgical episodes, accidents too,
That fell to my lot and the memory displeases,
As all painful happenings rightfully do.
When flu and pneumonia finally caught me
I learned emphysema and where it all led;
But worst was the thing that urology taught me,
The scourge of the bottle that stood by my bed.

Nephritis, hay fever, malarial shivers,
A fractured patella, a boil on my nose,
Appendix, the itch, Parkinsonian quivers,
Pleuritis, — these could not bring peaceful repose.
It is true carcinoma did somewhat disturb me,
And skull fracture leaving a dent in my head,
But these were as nothing and did not perturb me
As did the huge bottle that stood by my bed.

Sciatica, gall bladder, amyloidosis,
A fractured up spine with its big body cast,
And mumps with sequelae, hepatic cirrhosis,
A valvular heart that I thought was my last,
Nor asthma that seemed it would strangle and throttle
Were naught, nor was ulcer that painfully bled
Compared with that bottle, that brown gallon bottle,
That vile smelling bottle that stood by my bed.

REDUCING SCORES

I've seen the big and powerful blokes
Drive balls three hundred yards or more,
And thus by many, many strokes
Reduce their score.

I've seen the guys with level head
Make iron shots serenely soar,
And with approaches dropping dead
Reduce their score.

I've seen some men who putted so
The cup was like an open door,
Such putting, as we all well know,
Reduced their score.

I've also seen the crafty dub,
We have him with us evermore,
Whose tricky little pencil stub
Reduced his score.

THE NEUROLOGIST TESTIFIES

A workman got bumped with a piece of a brick
On the place where he wears his hat.
He was dressed by his doctor two or three times
Who thought that was the last of that.

But he soon found himself with arbitrator,
Attorney and neurologist,
Astonished to find that a piece of brick
Could do all the things that he'd missed.

He opens his eyes
In utter surprise
As the great neurologist testifies.

The man was schizophrenic,
And likewise neurasthenic,
His cauda was all snarled up in a knot.
With lues tertiary
And hemorrhage miliary,
His poor old pons Varolii was shot.

Anterior horns were twisted,
His cella was encysted,
And mentally there was no one at home
Total incapacitation
And a permanent vacation;
All because a piece of brick lit on his dome.

Do you wonder we all were mystified
When the great neurologist testified?

The man got his verdict; went back to work,
As such men so often do.
Attorney, neurologist went their way,
Defendant alone was blue.

L'Envoi

The neurologist's like the alchemist,
In the hoary days of old,
When he makes a humble piece of a brick
Worth more than its weight in gold.

ODE TO A GOOD SPORT

I sing the praise of thee, Good Sport;
Thou art a goodly wholesome sort,
Who does not muster forth vague alibis
And does not craftily improve his lies.
Thy temper ne'er grows hot,
Thou countest every shot,
Do not thyself long putts concede
But pay and smile, as is thy creed.
To Thee I humbly then present this ode,
Together with the dollar sixty owed.

A TRIOLET TO GOLF

When first we played we did not guess
That Golf would prove to be our master.
We played the game in gladsomeness,
When first we played we did not guess
Of blasted hopes and sore distress,
Nor dreamed 'twould prove a great disaster.
When first we played we did not guess
That Golf would prove to be our master.



In the severe depressions of the menopause

Many women in the climacteric period develop a true reactive depression, characterized by apathy and despondency.

● This depressive syndrome is frequently progressive; and, unless promptly and effectively treated, may seriously impair the patient's normal capacity for useful living. While estrogenic therapy and other basic treatments can do much to relieve these sufferers, many need further help if a prompt recovery is to be obtained.

● In such cases, Benzedrine Sulfate helps to reawaken mental alertness and optimism, and to restore the savor and zest of life.

● Obviously, Benzedrine Sulfate should not be used for the casual case of low spirits or normal physiologic depression as distinguished from true prolonged mental depression. Smith, Kline & French Laboratories, Philadelphia, Pa.

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20 cc. containing 0.48 Gm. (7½ grs.) (I.V.)

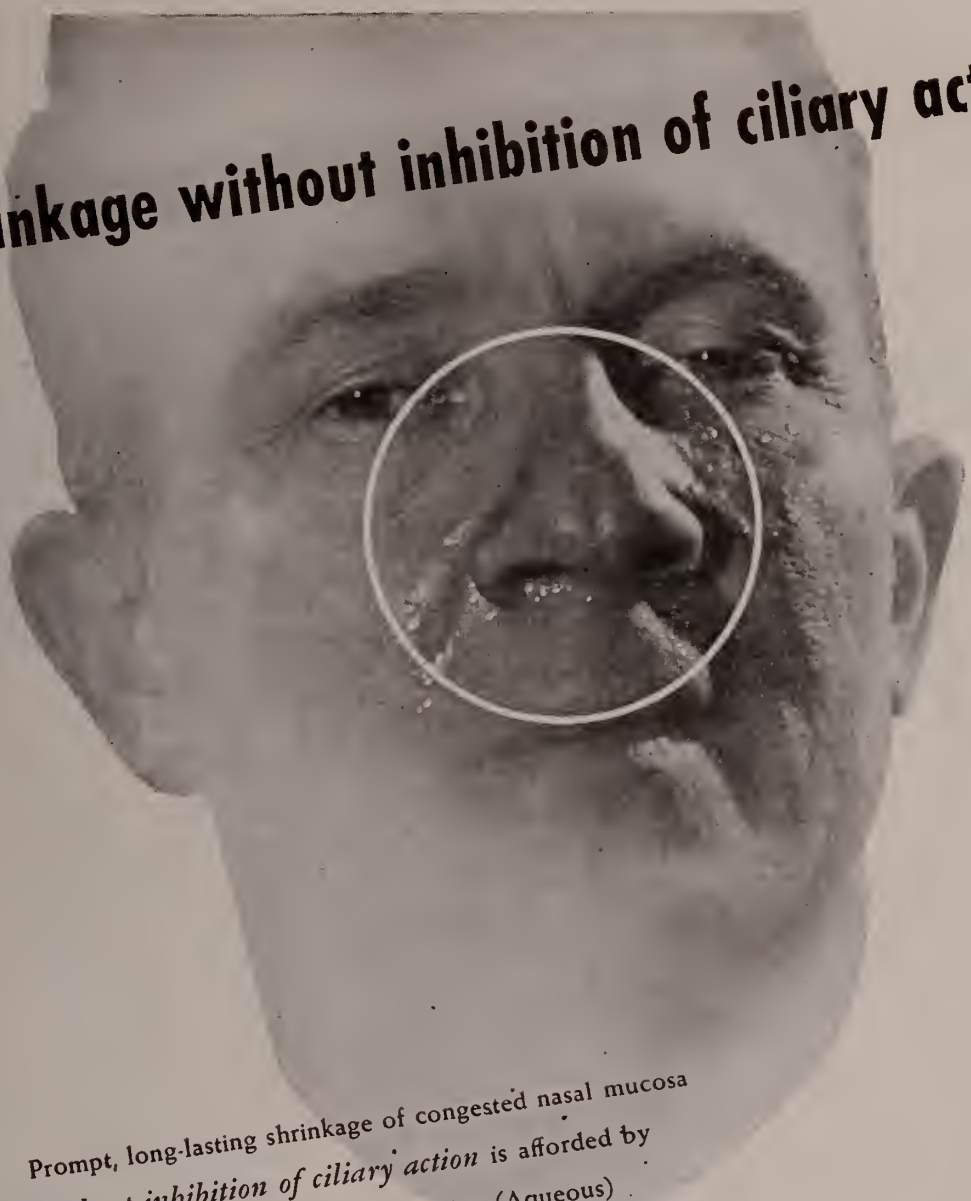
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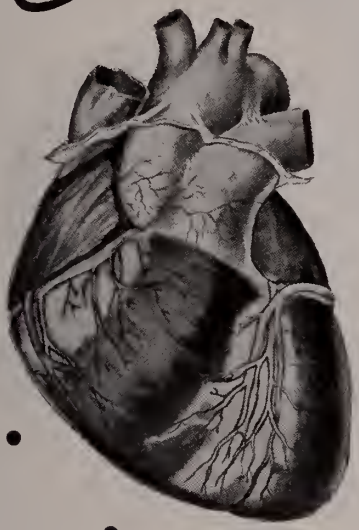
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(Continued on page 64)

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*N.N.R., 1944, page 303.



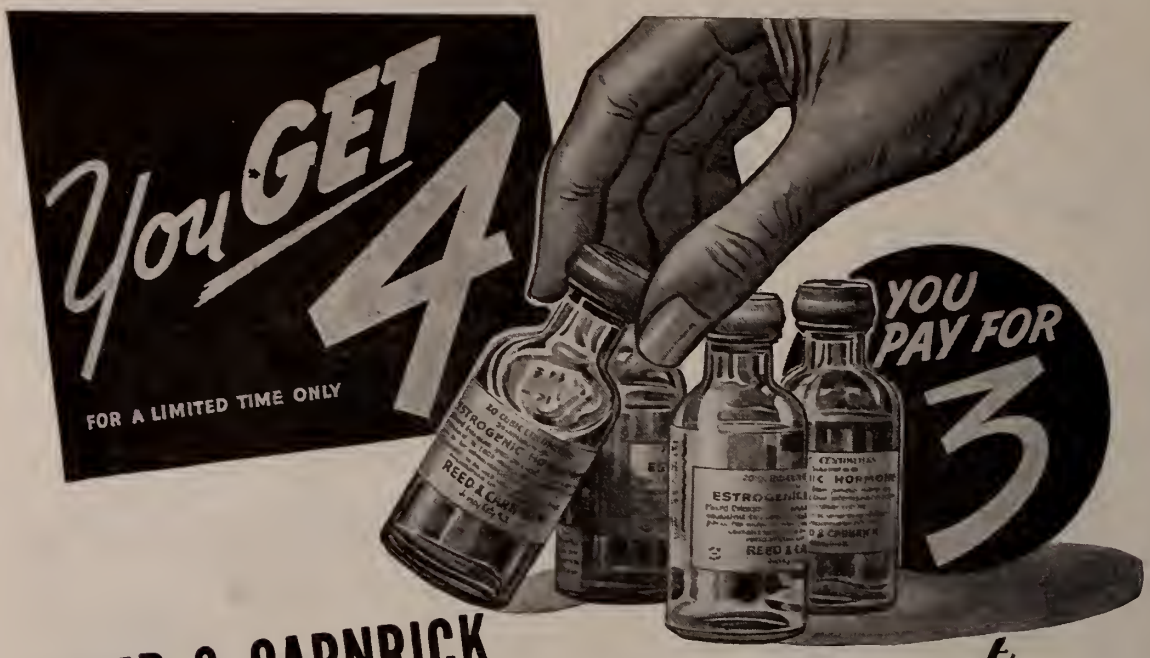
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Book Reviews

THE FUNDAMENTALS OF ELECTROCARDIOGRAPHIC INTERPRETATION: Second Edition. By J. Bailey Carter, M.D., F.A.C.P., Assistant (Rush) Professor, Department of Medicine University of Illinois College of Medicine; Attending Staff, Cook County Hospital, Augustana Hospital, Chicago. With a Foreword by Horatio Burt Williams, M.D., Dalton Professor of Physiology, College of Physicians and Surgeons, Columbia University, New York. Charles C. Thomas, Springfield, Illinois, 1945. Price $6.00.

Clinical Electrocardiography, a relatively recent development, has made rapid advancement in its value in the proper diagnosis of many previously obscure cardiac disturbances. Although not applicable as a diagnostic agency in some disturbances of the heart, its real value and some recently acquired information on the subject which did not appear in the first edition of this book published in 1937, are presented in this second edition. The book is intended primarily to give instructions so that the physician may interpret properly the electrocardographic findings without difficulty.

Doctor Carter repeatedly asserts that the diagnosis should not be made by the electrocardiogram, but that it is essential to give careful consideration to the history and examination findings, then correlate the data so procured to secure the correct interpretation of the electrocardiogram itself.

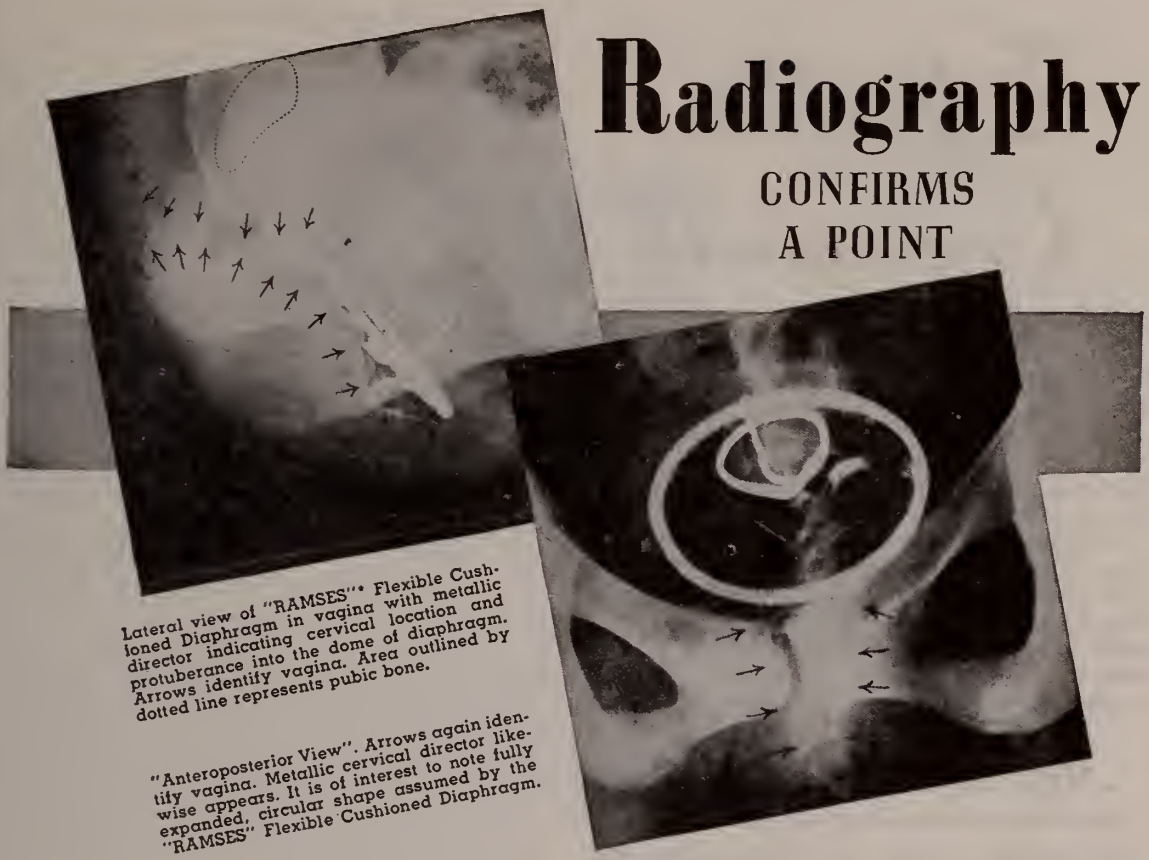
The first four chapters give the basic facts concerning the value of the electrocardiogram in clinical practice, the physiological basis and the origin and action of heart currents. Electrocardiographic technique and process of electrocardiography are discussed carefully. The waves of the normal electrocardiogram and individual wave changes are described in turn.

Electrocardiographic findings in various types of heart disturbances are all considered in the book. As would be expected, a considerable amount of space is devoted to consideration of coronary disease, especially coronary occlusion and its diagnosis. Early manifestations of rheumatic heart disease are frequently shown in the cardiogram before other evidence is

(*Continued on page* 46)

Radiography

CONFIRMS A POINT



Lateral view of "RAMSES"* Flexible Cushioned Diaphragm in vagina with metallic director indicating cervical location and protuberance into the dome of diaphragm. Arrows identify vagina. Area outlined by dotted line represents pubic bone.

"Anteroposterior View". Arrows again identify vagina. Metallic cervical director likewise appears. It is of interest to note fully expanded, circular shape assumed by the "RAMSES" Flexible Cushioned Diaphragm.

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BOOK REVIEWS (Continued)

available, and it is thought that a child with this infection is potentially a cardiac patient.

Throughout the book you will find discussed many diseases where electrocardiograms are essential in making the complete diagnosis. It is becoming more obvious each day that occasionally changes in the cardiogram actually give the first clue as to the exact nature of the disturbance. As would be expected in a book of this type, there are more than 300 figures which add materially to the value and aid in the interpretation of electrocardiographic findings.

The aim of the book, to aid the beginner in acquiring a practical knowledge of electrocardiographic interpretation, is properly justified as you will note by the careful manner in which the author brings out the fundamentals, then the interpretation of the cardiogram itself. The book should be of value to those who desire to go into this strictly modern subject further, and the popularity of the book should be increased materially with the appearance of this second edition.

MICROBIOLOGY AND PATHOLOGY: By Charles F. Carter, B.S., M.D., Instructor in Microbiology and Pathology, Parkland Hospital School of Nursing, Dallas, Texas; Director, Carter's Clinical Laboratory, Dallas, Texas; Consulting Pathologist, St. Louis Southwestern Railway Hospital, Texarkana, Arkansas; Consulting Pathologist, Mother Frances Hospital, Tyler, Texas; Formerly Director of Laboratories, Parkland Hospital. With 200 Text Illustration and 25 Color Plates. Third Edition. St. Louis. The C. V. Mosby Company, 1944. Price $3.50.

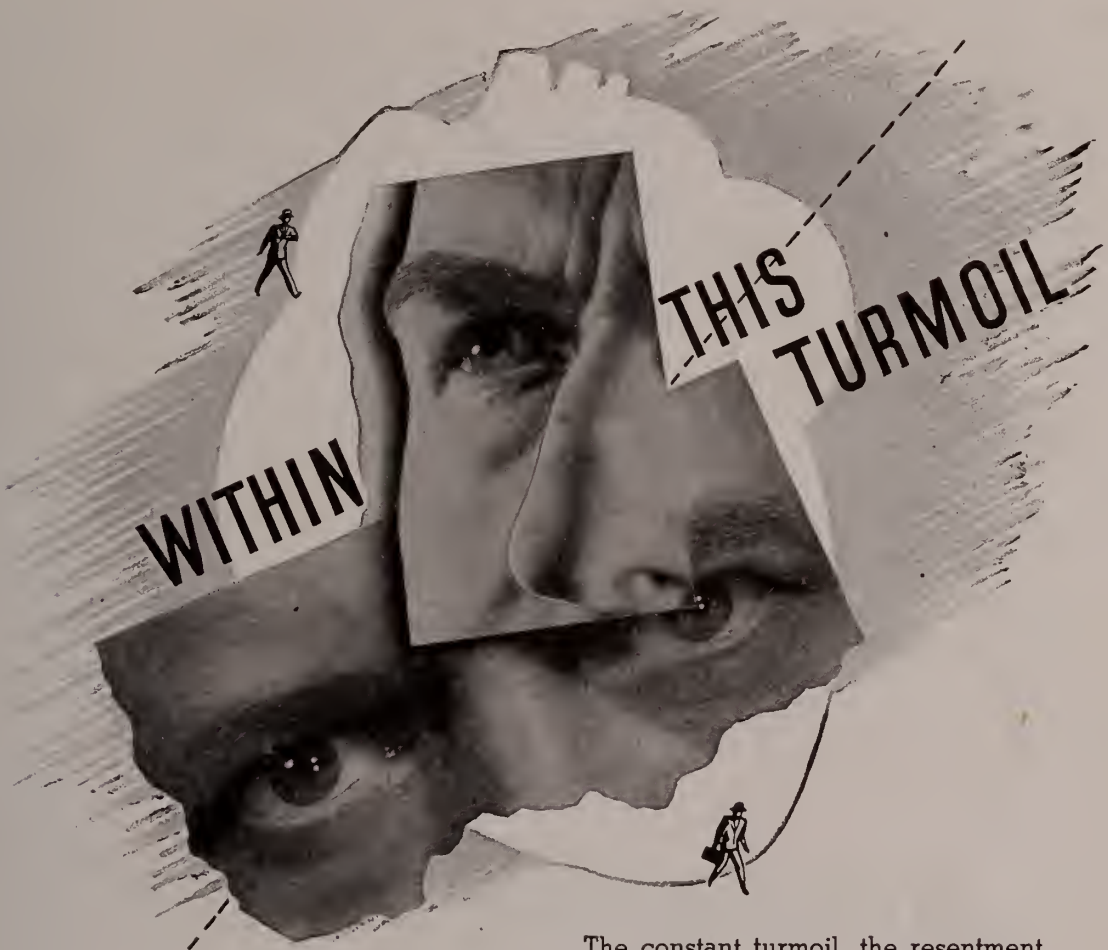
Some years ago this author wrote a book, "Bacteriology for Nurses" which was quite popular. The first edition of this book was the outgrowth of the former volume and appeared in 1936. Doctor Carter endeavored to show how bacteria get into the body, how the body endeavors to resist them, why disease is produced in some patients and not in others in spite of bacterial invasion, then the pathologic findings in microbic infections.

With the ever advancing knowledge in the practice of medicine, and with newer concepts concerning certain diseases, methods of combatting them, including the use of some of the recently developed antibiotics, necessitated the book being brought up to date. The author states that much material has been added in this third edition, while other less essential data has been removed, so that the size of the volume is but little changed. Some chapters were almost entirely rewritten in the process of modernizing this material.

The book is divided into three parts; the first deals with the subject of microbiology and deals with the subjects, General Principles of Microbiology, Relation of Bacteria to Disease, Bacteriology of Water and Milk, and Special Bacteriology.

Part II is devoted to the consideration of Pathology,

(*Continued on page* 48)



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BOOK REVIEWS (Continued)

its importance, naturc of disease, causes of disease, defenses of the body against diseasc, tissue changes, infectious diseases, then in a general way, deals with diseases of various parts of the body and the pathological results.

The third part of the book consists of laboratory exercises which, when followed by the class of nurses, will give them first hand information concerning various laboratory procedures. This illustrates well many of the statcments made in the text itself, covering both microbiology and pathology.

Having taught microbiology and pathology in a large training school for nurses over a period of years, the author has brought out a text which should be quite popular in many training schools throughout the country.

PHYSICAL DIAGNOSIS: By Ralph H. Major, M.D., Professor of Medicine, The University of Kansas, Kansas City, Kansas. Third Edition. Revised. 444 pages with 458 illustrations. Philadelphia and London: W. B. Saunders Company, 1945. Price $5.00

As stated by the author, physical diagnosis is not static, but advances with each important discovery in medicine. As a teacher of physical diagnosis in a medical school, the author has had many years of experience as a teacher as well as a clinician which equips him well for the responsibility of producing an excellent text on this important subject.

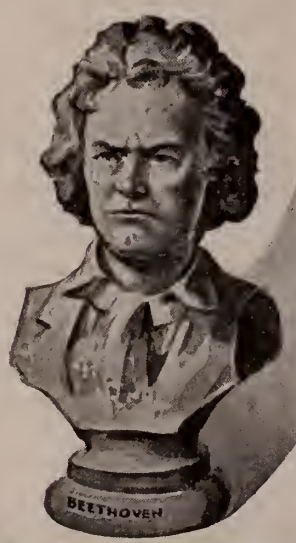
Doctor Major states that he is indebted to many colleagues as well as to students, for the many suggestions which have been received since the publication of the last edition of his book in 1940. Beginning with a carefully taken history, the author again firmly believes that inspcction, palpation, percussion and asuculation, in this order, comprise the major functions in the examination of patients. He, of course, recognizes the necessity of utilizing other diagnostic accessories, but these should be done after the above procedures have been followed meticulously.

After a general consideration of pain, the author carefully describes the necessary procedures in making a careful examination of the human body, emphasizing the importancc of various findings and describing many of the pitfalls which may lead to disaster on the part of the careless examiner.

The book should be of inestimable value to the student and will be of much intcrest to the practitioner desiring to refresh his memory and improve his technique in making physical examinations. The previous editions have been extremely popular and there is no reason to believe that the third edition should not maintain this high interest value.

(*Continued on page* 50)

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BOOK REVIEWS (Continued)

SYNOPSIS OF CLINICAL LABORATORY METHODS: By W. E. Bray, B.A., M.D., Professor of Clinical Pathology, University of Virginia; Director of Clinical Laboratories, University of Virginia Hospital. Ninety-Three Text Illustrations. Twenty Color Plates. Third Edition. St. Louis. The C. V. Mosy Company, 1944. Price $5.00.

Like many books recently brought up to date, the many changes in medicine in recent years have made it necessary to revise completely this material and bring out the third edition. The ever increasing importance of the Rh factor, necessity for determining blood levels for the sulfa and other new drugs, additional information now available concerning intestinal parasites, are a few of the reasons for the present edition.

The form of the book is quite similar to the last edition even though there has been a marked change in the text material, illustrations and charts. With the increasing importance of blood transfusions, many new headings will be found in the chapter on hematology. Blood chemistry likewise increasing in importance and scope, is well covered in the text.

This pocket size manual with 528 pages, ninety-three text illustrations and twenty color plates, will be of intense value to students as well as to many technicians and also to those who must make many of their own laboratory tests.

A MANUAL OF SURGICAL ANATOMY: Prepared under the Auspices of the Committee on Surgery of the Division of Medical Sciences of the National Research Council, by Tom Jones and W. C. Shepard. 195 pages with 267 illustrations on 138 figures, 153 in colors. Philadelphia and London. W. B. Saunders Company, 1945. Price $5.00.

This is another in the already popular series of Military Surgical Manuals developed under the auspices of the Division of Medical Sciences of the National Research Council to furnish the medical departments of the army and navy with compact presentations of necessary information in the field of Surgery. With forewords by the Surgeons General of the U. S. Army and the U. S. Navy in which both highly approve this volume, it is predicted that this volume will continue to be more popular after the war is ended, than the other manuals which have been prepared previously for the use of the Army-Navy Medical Corps.

An effort has been made to make it easier for the surgeon to refresh his memory of the anatomical features likely to be involved in an operation on any part of the body.

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(*Continued on page* 54)

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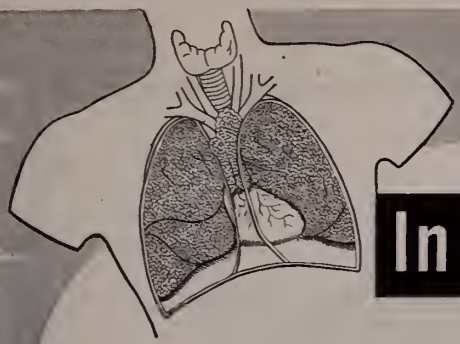
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*Stainsby, W. J.; Foss, H. L., and Drumheller, J. F.: Clinical Experiences with Penicillin, Pennsylvania M. J. 48:119 (Nov.) 1944.

McBryde, A.: Hemolytic Staphylococcus Pneumonia in Early Infancy; Response to Penicillin Therapy, Am. J. Dis. Child. 68:271 (Oct.) 1944.

Stainsby, W. J., Chairman, Commission for the Study of Pneumonia Control of the Medical Society of the State of Pennsylvania: Up-to-Date Facts on Pneumonia, Pennsylvania M. J. 48:266 (Dec.) 1944.

Larsen, N. P.: Observations with Penicillin, Hawaii M. J. 3:272 (July-Aug.) 1944.

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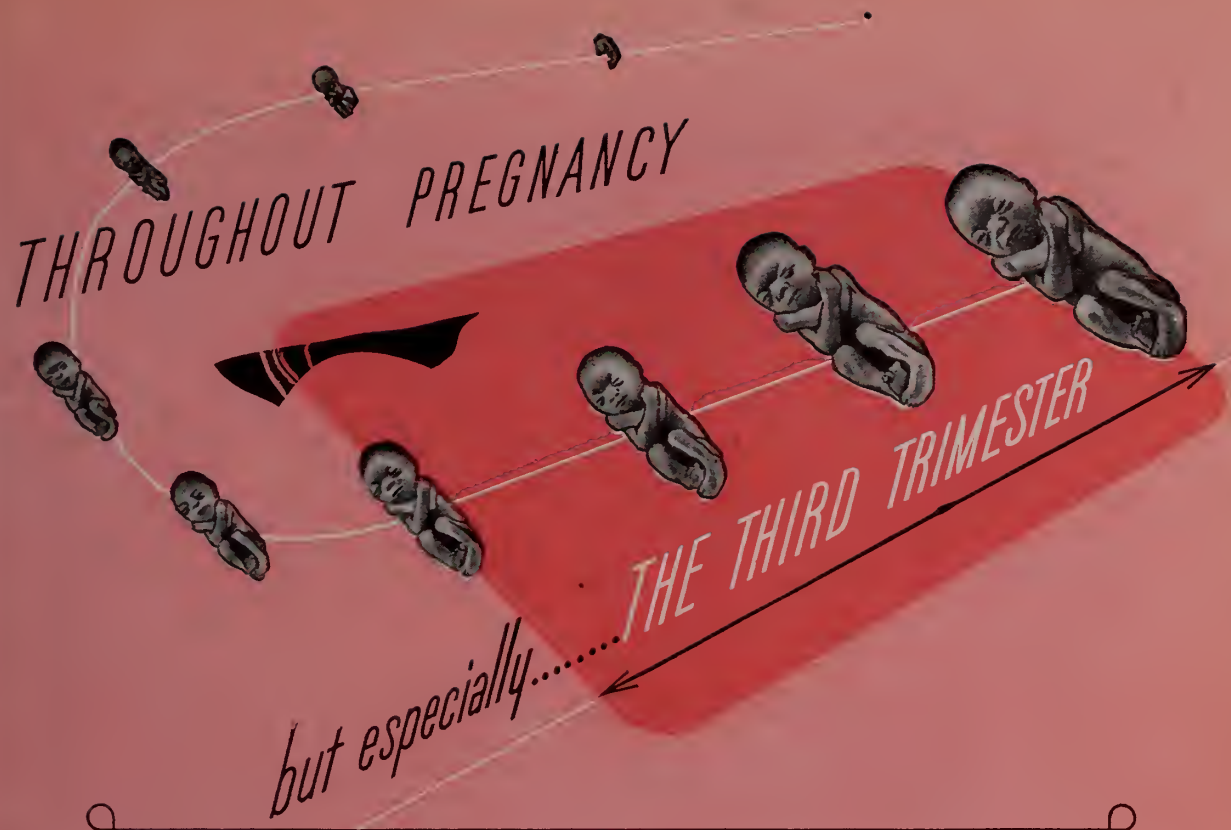
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BOOK REVIEWS (Continued)

begins with the bones, ligaments, muscles, veins and nerves, then shows many dissections and continues with the surgical approaches.

Having been prepared under the supervision of a group of master surgeons and by two of the outstanding anatomical artists, the popularity of the book should continue for a long period of time.

THE DENTAL TREATMENT OF MAXILLO-FACIAL INJURIES: With Supplement Material on Cases and Techniques: By W. Kelsey Fry, M.C., M.R.C.S., L.R.C.P., L.D.S., R.C.S. (Eng.) Consulting Dental Surgeon to the Royal Air Force, Consulting Dental Surgeon to the Ministry of Health, Dental Surgeon to Guy's Hospital; P. Rae Shepherd, L.D.S., R.C.S., (Eng.) Dental Suregon, East Grinstead Maxillo-facial Unit; Allan C. McLeod, D.D.S. (Penn.) B.Sc. (Dent.) Toronto, L.D.S., R.C.S., (Eng.) Dental Surgeon, East Grinstead Maxillo-facial Unit; Gilbert J. Parfitt, M.R.C.S., L.R.C.P., L.D.S., R.C.S., (Eng) Dental Surgeon, East Grinstead Maxillo-facial Unit. With Foreword by Professor F. R. Fraser, M.D., F.R.C.P., Director General, Emergency Medical Service; and a Section on Fractures of the Middle Third of the Fact by A. H. McIndoe, M.S., F.R.C.S., F.A.C.S., Consulting Plastic Surgeon to the Royal Air Force, Surgeon-in-Charge, East Grinstead Maxillo-facial Unit. J. B. Lippincott Company, Philadelphia, Montreal. Price $6.50.

This American edition combines the original work, "The Dental Treatment of Maxillo-facial Injuries" and the supplement which were published in two volumes in England. The substance of the book is comprised of material given through lectures to medical officers at an English maxillo-facial centre, realizing that in war time many such injuries are received.

After a review of the anatomical structures involved in maxillo-facial injuries the authors present in detail the various types of fractures and the locations where they are commonly seen. Then follows the diagnosis with special emphasis on radiological findings and proper interpretation of films, general considerations relative to feeding and general care; reduction and fixation to give maximum results. Surgical procedures deemed necessary in the reduction and treatment of these injuries are described carefully.

The various fixation methods are described, including the use of wires and pins as well as several types of splints which are occasionally employed in fixation of maxillo-facial fractures. As osteomyelitis is uncommon as a complication in this type of case, but little reference is given to its treatment. A considerable amount of space is devoted to prosthetic restora-

(*Continued on page* 56)

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BOOK REVIEWS (Continued)

tion in cases of considerable bone loss, as it is not possible to use a bone graft or approximate a bone loss of the upper jaw in any other way.

The book should be of general interest to those responsible for the care of this type of case, which falls into the field of the dental surgeon, or those interested in the various ramifications of oral surgery in general. Based upon studies of many cases observed during warfare, it is quite obvious that the conclusions of the author will be approved by those interested in this field, and the book should become as popular in America as it has been in England.

ARTERIAL HYPERTENSION: Its Diagnosis and Treatment; By Irving H. Page, M.D., and Arthur Curtis Corcoran, M.D., Research Division of the Cleveland Clinic Foundation, Cleveland; Formerly Lilly Laboratory for Clinical Research, Indianapolis City Hospital, Indianapolis. The Year Book Publishers, Inc., 304 S. Dearborn St., Chicago. Price $3.75.

This is another of the ever popular General Practice Manuals published frequently by the Year Book Publishers, Inc. It pertains to a subject which is of continuous importance to all practicing physicians, and one which is seen daily in the average medical practice.

The book is divided into five sections, the first of which deals with normal blood pressure, the classification of hypertension, tests designed to measure vascular responsiveness and the early stages of hypertension. The second section is devoted to the consideration of essential and malignant hypertension, physical examination and the psychotherapy of hypertension.

The third section discussed circulation in early hypertension, clinical considerations emphasizing especially the thoracic zone, estimation of arterial pressure, cardioaortic roentgenology and the electrocardiogram. Section four refers to hypertensive heart disease with special consideration of angina pectoris and coronary insufficiency, coronary thrombosis and myocardial infarction, and congestive heart failure. Special consideration is given to the kidneys in hypertension, their function, tests of renal function and renal failure. Likewise discussed is the ever important subject of hypertension and pregnancy.

Section five gives treatment with the popular therapeutic remedies, treatment by nephrectomy and the surgical handling of hypertension. An appendix refers to a classification of the toxemias of pregnancy, the estimation of cardiac hypertrophy. The chapter on surgical treatment discusses the four popular surgical procedures which have been developed, each of which has its advocates; the supradiaphragmatic splanchnicectomy and ganglionectomy as developed by Peet; subdiaphragmatic splanchnicectomy and ganglionectomy of Adson and Craig; combined supra and infradiaphragmatic ganglionectomy of Smithwick, and the "total" sympathectomy of Grimson. These surgical procedures are outlined in detail and the author states that the various types of operations which have been

(*Continued on page* 58)



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*"Bactericidal Efficiency of Iodine Solutions and Organic Mercurial Antiseptics", Amer. Jour. Pharm., 117:5 (Jan.) 1945.

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BOOK REVIEWS (Continued)

performed are necessary experimental steps in the development of the treatment of hypertension by surgery.

The book will be of much interest to any physician who will read it, and it is quite obvious that the reader will find that he has been well repaid for his time and effort.

MANUAL OF UROLOGY: By R. M. LeComte, M.D., F.A.C.S., Professor of Urology, Georgetown University Medical Department, Member of the American Urological Association. Third Edition. The Williams and Wilkins Company, Baltimore, 1944. Price $4.00.

The author brought out the first edition of this book in 1933 primarily for the student to acquaint himself with the essentials of urology. The book appeared in its second edition in 1939, and this third edition came off the press in 1944. Included are the recent advances in chemotherapy and their uses in urology; injuries to the genito-urinary tract which should make the book of interest to our men in service, and many illustrations not presented in the previous editions.

Considerable space is devoted to the methods of examination, symptomatology and methods of treatment, all of general interest to students as well as those in general practice desiring reliable information on the essentials of urologic work. Then in turn, surgical diseases of the kidneys, diseases of the bladder, prostate, seminal vesicles, urethra, penis and diseases of the scrotal contents are presented in detail.

The last chapter, "Impotence and Sterility in the Male" should be of much interest to the many physicians who are questioned so frequently by patients who have read recent releases on the rejuvenation of middle aged or elderly men by the use of endocrine substances. The proper answer to many of the questions propounded may be forthcoming after this chapter has been read.

The book should be most popular with students as well as those in general practice desiring a compact manual on a subject of general interest. It should aid

(*Continued on page* 62)

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materially in solving many of the problems presenting themselves in routine clinical work.

PENICILLIN THERAPY: Including Tyrothricin and Other Antibiotic Therapy; By John A. Kolmer, M.S., M.D., Dr.P.H., Sc.D., LL.D., L.H.D., F.A.C.P., Professor of Medicine in the School of Medicine and the School of Dentistry, Temple University; Director of the Research Institute of Cutaneous Medicine; Formerly Professor of Pathology and Bacteriology, Graduate School of Medicine, University of Pennsylvania. D. Appleton-Century Company, Inc., New York, London. Price $5.00.

During the four years since Florey and associates isolated penicillin in pure form and discovered its effects in the treatment of infections, much progress has been made along the lines of large scale manufacture of the finished product. At first available for civilian use in relatively small quantities, American ingenuity came to the rescue and today there is a supply available everywhere for those conditions in which penicillin is indicated.

The author has developed a worth while monograph on this subject and has reviewed an immense amount of literature. Beginning with the antibiotics in general, he refers in detail to the production of penicillin, methods for the detection and assaying, its physical and chemical properties and its antimicrobal activity in vitro and in vivo.

Much information is given relative to the administration and dosage of penicillin and the principles of penicillin therapy. Then in turn, reference in detail is made to the use of penicillin in various bacterial infections for which it has been shown to be definitely indicated. As would be expected in a modern book on this subject, much information is given relative to the use of penicillin in syphilis and gonorrhea. At this time it is perhaps the remedy of choice in treating gonorrhea, and cures are frequently reported within a period of less than 24 hours from time of institution, although there are definite methods and dosage which must be clearly understood by the physician using it in this disease.

As shown by the author, much work is being done at this time in the treatment of syphilis, both in the acute and latent stages, with some success, although the exact status of penicillin as a remedy of choice in this disease has not as yet been definitely established.

The author, to make the book complete, also reviews in detail other antibiotics which are being used clinically or experimentally at the present time. Among these are tyrothricin, gramicidin S., streptothricin, patulin and chlorophyll.

The book will be of much value to everyone practicing medicine today as a work carefully prepared and developed after the author has reviewed carefully the voluminous amount of literature on the subject.

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INSANITY, DUE TO SYPHILIS, TREATED WITH PENICILLIN

In an attempt to develop effective treatment for chronic dementia paralytica, the dreaded type of insanity due to syphilis, three Chicago physicians used penicillin to treat five patients. Clarence A. Neymann, M.D., Gert Heilbrunn, M.D., and G. P. Youmans, M.D., make their report in the June 9 issue of *The Journal of the American Medical Association.*

Dementia paralytica is characterized by early changes in personality, progressive loss of mental and physical power, and generalized paralysis which terminates in death. Mental symptoms had been present in all five patients from one to ten years. Three of them died and only one improved. This female patient had shown mental symptoms for four years. Her symptoms included a shuffling and staggering gait, pronounced confusion and incoherent speech. After four injections of penicillin her mental condition improved considerably, and her speech became more coherent.

The fact that an individual reacts to tuberculin immediately arouses his interest in tuberculosis and he desires facts concerning the potentialities of the infection. The logic of periodic examinations, including X-ray film inspection of the chest becomes obvious, whereas, if only an X-ray film inspection is made of the chest and is reported normal, it is often exceedingly difficult to convince the individual that subsequent periodic examinations are indicated. To us it seems far better to concentrate on the small percentage of tuberculin reactors where potential clinical tuberculosis exists than to devote time and energy to making X-ray inspections of the much higher percentage in whom there is no possibility of finding clinical tuberculosis. Lewis S. Jordan, M.D., Journal-Lancet, April, 1945.

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U. S. DOCTORS BANNED IN MEXICO

United States physicians are virtually excluded from practicing medicine in Mexico, *The Journal of the American Medical Association* reports in its June 23 issue. According to *The Journal's* Mexico City correspondent, a new and rigid federal law, designed to eliminate foreign influences from the Mexican scientific professions, went into effect on May 28. The law, which lays down a complete system of control for a number of professions, is important in its limitation as far as American doctors are concerned. The statute declares that "no foreigner can practice, in the Federal District and territories, the scientific professions covered by this law." The medical profession is particularly named as one of the fields which has been closed to foreigners.

American physicians already practicing in Mexico, however, probably will not be affected, government sources indicated. These doctors, who comprise some of the country's leading medical authorities, may be required to register their qualifications with the General Bureau of Professions, the government agency which will administer the legislation. Another exception will be made for refugee physicians, who will be conceded "temporary permits" to practice, provided they are able to "prove themselves to be the victims of political persecution in their own country."

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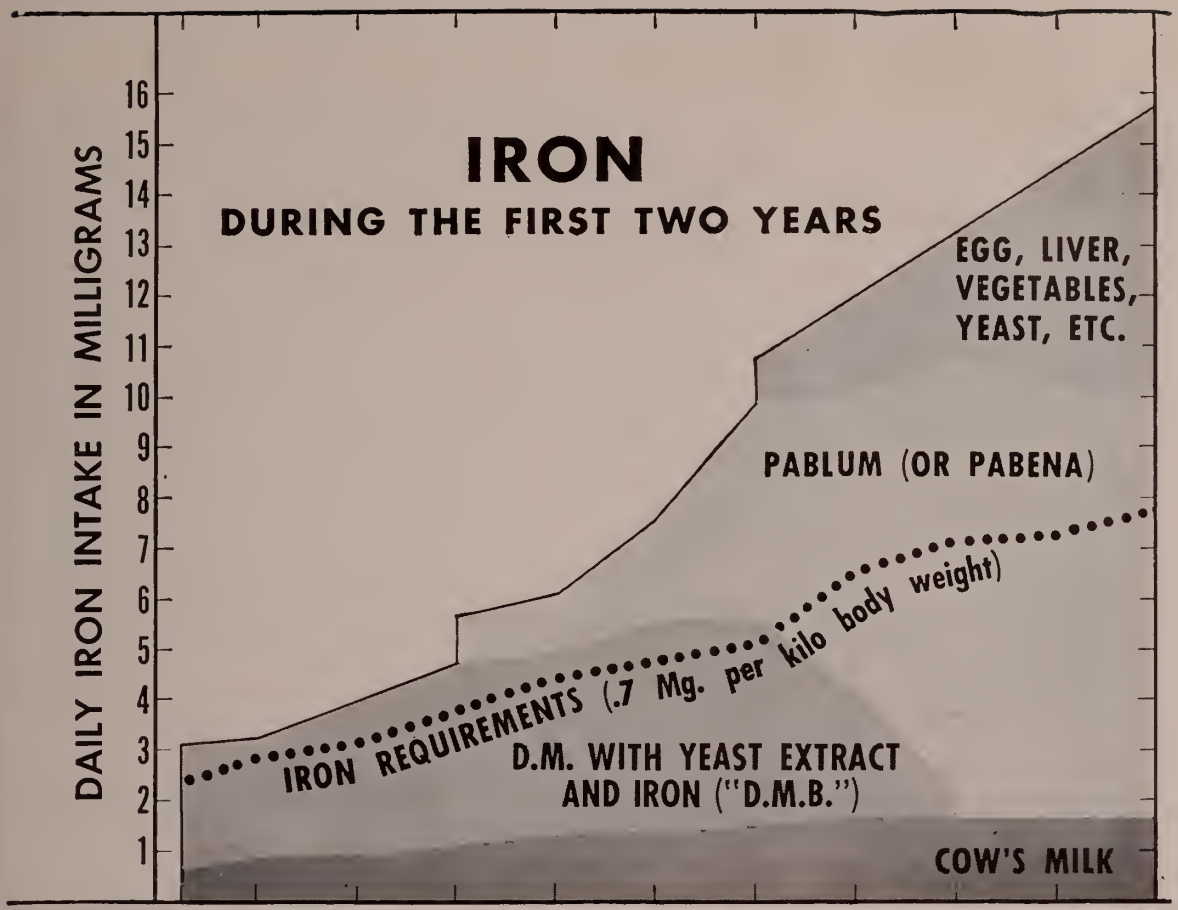
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September, 1945

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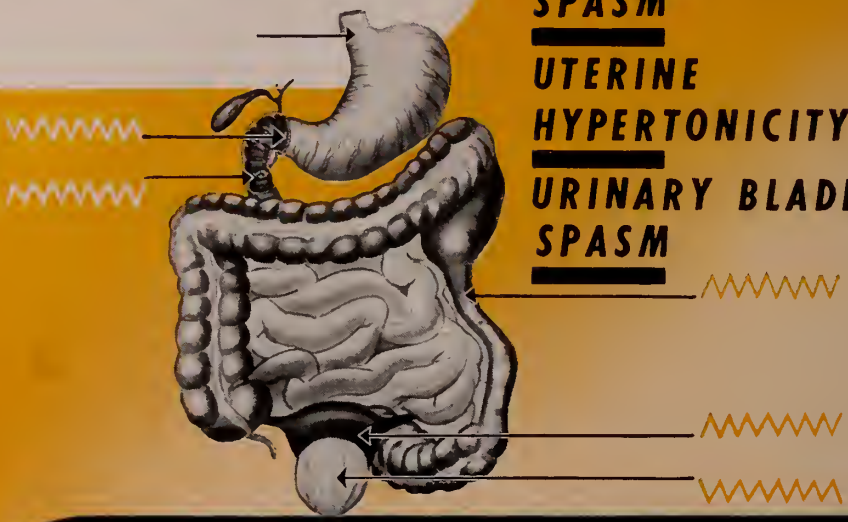
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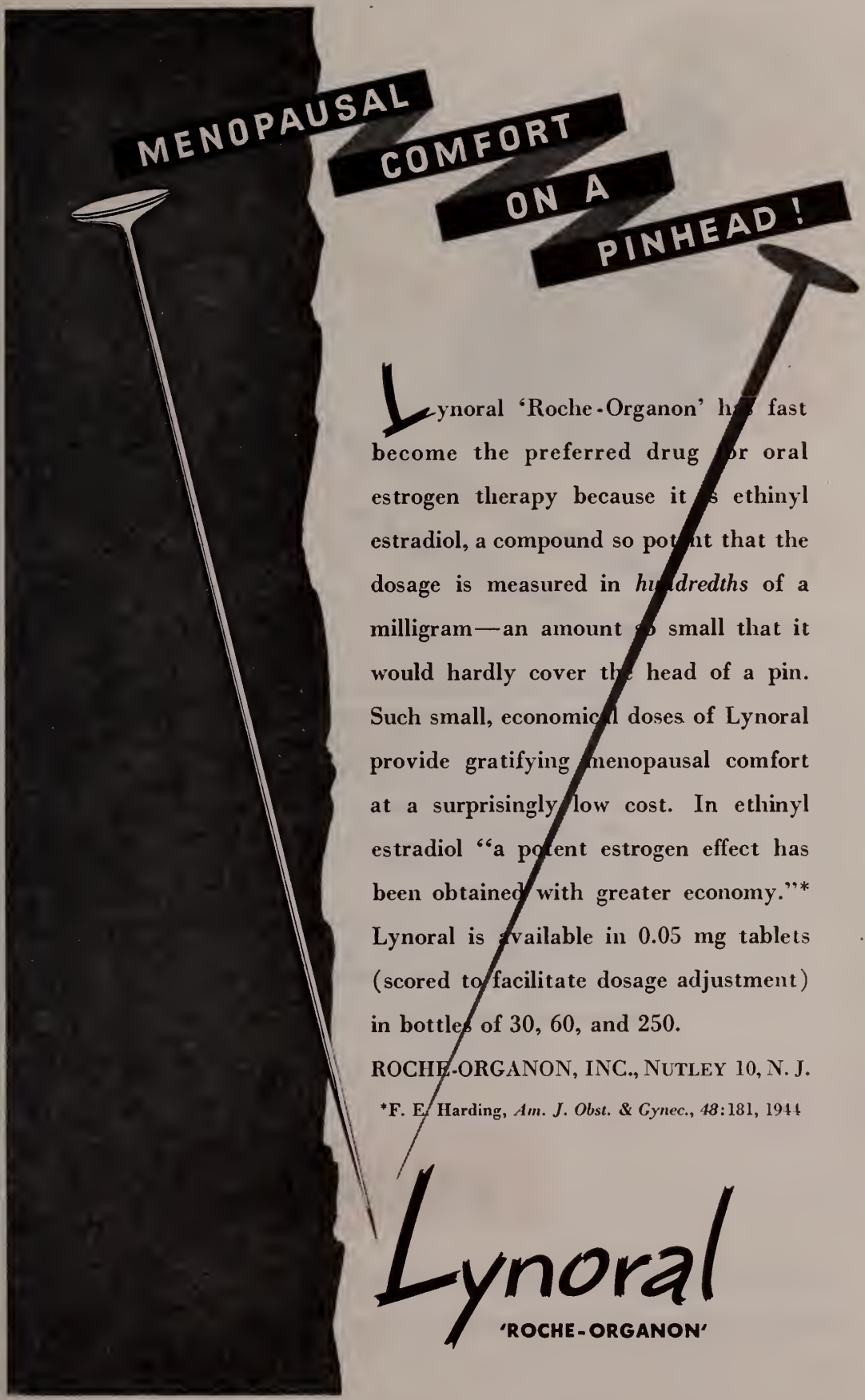
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*F. E. Harding, *Am. J. Obst. & Gynec.*, *48*:181, 1944

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In utilizing the synergistic actions of Calpurate, ephedrine and phenobarbital—EPURAL becomes a potent bronchodilator and sedative, significantly free from untoward central and cardiac side-effects.

For symptomatic treatment of bronchial asthma, hay fever and allergic coryza, EPURAL offers the therapeutic advantage of providing *prolonged bronchodilatation*, and effecting *safe sedation*, which serves to counteract the natural tendency of ephedrine (when used alone) to stimulate the central nervous system.

While EPURAL may be safely administered over protracted periods, with freedom from gastric disturbances, it should be used with caution in hyperthyroidism, diabetes mellitus, and severe cardio-renal disease.

FORMULA: Calpurate (calcium theobromine—calcium gluconate) . 4 gr.
Ephedrine sulfate ¼ gr.
Phenobarbital ¼ gr.
In bottles of 100, 500 and 1,000 tablets.

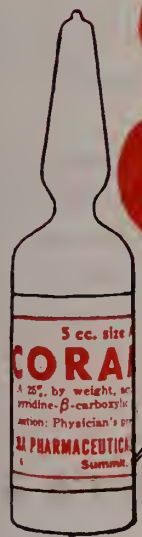
EPURAL

For Safe, Symptomatic Relief of Allergic Respiratory Conditions

THE MALTBIE CHEMICAL COMPANY, NEWARK, NEW JERSEY

In critical moments

5 cc. or more



Many years of clinical experience with CORAMINE* (pyridine-beta-carboxylic acid diethylamide) have demonstrated that satisfactory results cannot be expected from an injection of an inadequate quantity in shock conditions. A single intravenous injection of at least 5 cc. is necessary to restore respiration and circulation, as well as to increase intramuscular pressure. Subsequent maintenance dosage of 1.5, 3.0, or even 5.0 cc. intramuscularly three or four times daily usually follows.

SHOCK due to trauma, surgery, anesthesia, extensive burns.

ASPHYXIA — neonatorum, drowning.

POISONING due to opiates, hypnotics, alcohol, carbon monoxide.

CORAMINE

5 cc. Ampuls — Cartons of 3 and 12

*Trade Mark Reg. U.S. Pat. Off.

a Ciba Product

CIBA PHARMACEUTICAL PRODUCTS, INC.
SUMMIT, NEW JERSEY
IN CANADA, CIBA COMPANY LIMITED, MONTREAL

vasoconstriction in minute

In the treatment of nasal and sinus infections, Paredrine-Sulfathiazole Suspension . . .

1. Affords more rapid, complete and prolonged shrinkage than that produced by ephedrine in equal concentration. Ventilation and drainage are promptly promoted and infected areas are quickly rendered accessible to the sulfathiazole.

2. Provides prolonged bacteriostasis. Paredrine-Sulfathiazole Suspension covers the nasal mucosa with a fine, even frosting of free sulfathiazole, which does not quickly wash away, *but keeps producing bacteriostatic act hour after hour.* (An objection to solutions of sodium sulfathiazole is the improbability of their remaining in contact with the mucosa long enough to be effective.)

Smith, Kline & French Laboratories—Philadelphia, Pa.

PAREDRINE—SULFATHIAZO




cteriostasis for hours
ISPENSION



When the pressure is low—
the circulation slackens

In chronic hypotension or states of circulatory deficiency associated with convalescence, mild collapse, and other asthenic states, Sympatol provides convenient symptomatic therapy. Orally effective, Sympatol improves the peripheral circulation by raising systolic and venous pressure and increasing cardiac output. Circulation time is shortened although the pulse rate is frequently slowed.

Sympatol

To Improve Peripheral Circulation

THERAPEUTIC APPRAISAL: A synthetic pressor drug—para-methylaminoethanolphenol tartrate—for providing safe circulatory stimulation. Sympatol, on oral administration, increases venous and systolic pressures significantly, diastolic pressure only slightly, with little or no effect on the central nervous system. Repeated doses are consistently and uniformly effective.

INDICATED for symptomatic treatment of circulatory atony—to improve peripheral circulation; to increase cardiac output and shorten circulation time; to increase cardiac efficiency.



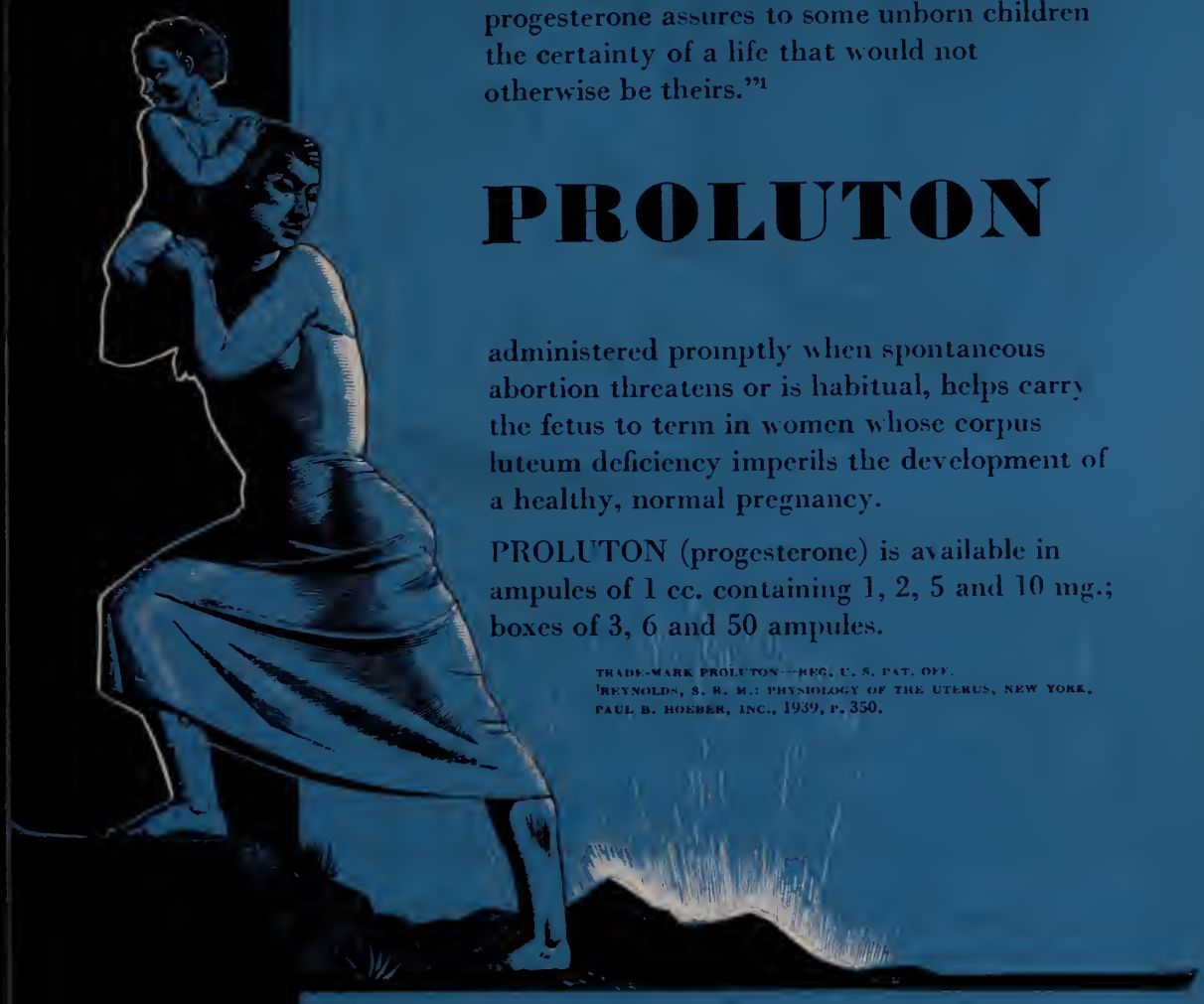
DOSAGE: Adults—1 to 3 tablets three times daily, or 1 to 2 cc. of solution every four to six hours. Children—5 to 20 minims of solution repeated as required.

SUPPLIED in 100 mg. tablets, bottles of 50; 10% solution (100 mg. per cc.) for oral use, bottles of 30 cc.

Frederick Stearns & Company
Division
DETROIT 31, MICHIGAN

NEW YORK KANSAS CITY SAN FRANCISCO WINDSOR, ONTARIO SYDNEY, AUSTRALIA AUCKLAND, NEW ZEALAND

Trade-Mark Sympatol Reg. U. S. Pat. Off.



"Hope need not be dispelled in those women who, in the usual course of events, could not have the experience of motherhood . . . the judicious use of progesterone assures to some unborn children the certainty of a life that would not otherwise be theirs."[1]

PROLUTON

administered promptly when spontaneous abortion threatens or is habitual, helps carry the fetus to term in women whose corpus luteum deficiency imperils the development of a healthy, normal pregnancy.

PROLUTON (progesterone) is available in ampules of 1 cc. containing 1, 2, 5 and 10 mg.; boxes of 3, 6 and 50 ampules.

TRADE-MARK PROLUTON—REG. U. S. PAT. OFF.

[1]REYNOLDS, S. R. M.: PHYSIOLOGY OF THE UTERUS, NEW YORK, PAUL B. HOEBER, INC., 1939, P. 350.

SCHERING

Schering CORPORATION · BLOOMFIELD · N.J.



WITHOUT COLOR, even Nature, with all her infinite powers, is handicapped in creating a picture of health. This is particularly true in secondary anemia.

To restore full color to defective, iron-deficient blood, Arsenoferratose ELIXIR has been the preferred hematinic of many physicians for over 20 years. Distinctive for its *palatability,* this organic-iron is readily accepted by both children and adults. Moreover, *it does not cause gastric irritation or stain the teeth.*

SUPPLY: **Arsenoferratose** and **Arsenoferratose With Copper,** 8 oz. and pint bottles. **Ferratose and Ferratose-C** (latter contains copper), pint bottles.

Literature and samples to physicians on request

RARE CHEMICALS, INC.
Harrison, New Jersey
West Coast Distributors: GALEN COMPANY, Berkeley 2, California

ARSENOFERRATOSE

Reg. U. S. Pat. Off.

PALATABLE HEMATINIC

RESTORES FULL COLOR TO DEFECTIVE, IRON-DEFICIENT BLOOD

820



Red comfort

Serenium soothes inflamed genito-urinary membranes while possessing low toxicity and a wide margin of safety. Effective in either acid or alkaline urine, this red dye (diamino-4'-ethoxy-azobenzene hydrochloride) halts the growth of most bacterial urinary invaders. Administered orally, Serenium tablets ease the patient's discomfort and constitute an effective weapon against genito-urinary infections.

SQUIBB

Serenium
TRADEMARK

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858



"ESTROGENS IN CLINICAL PRACTICE"

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AYERST, McKENNA & HARRISON LTD.,
ROUSES POINT, N.Y.

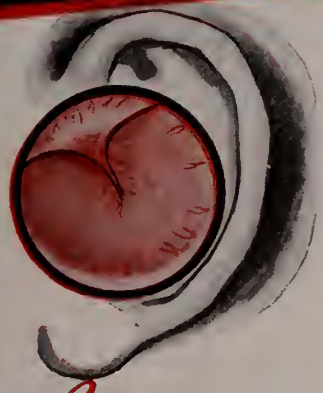
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Medications of Choice FOR THE SPECIFIC INVOLVEMENT



Auralgan

in ACUTE OTITIS MEDIA

Symptoms

Pain, fever, edema, leucocytosis, sense of fullness and impaired hearing.

Treatment

Relief of pain and inflammation—*Auralgan.*

Action

Decongestant, analgesic, bacteriostatic.

Scientific data and reprints of clinical studies reporting upon the use of Otosmosan available on request.



Otosmosan

in CHRONIC SUPPURATIVE OTITIS MEDIA

Symptoms

Persistent discharge, often foul smelling, usually no toxemia, no pain, no fever.

Treatment

Otosmosan.

Formula

Sulfathiazole carbamide 20% in glycerol (Doho).

Action

Deodorizes the discharge, liquifies unhealthy granulations, bacteriostatic, permits normal epithelialization.

Complimentary quantities for clinical trial

THE DOHO CHEMICAL CORPORATION

New York 13, N. Y. • Montreal • London

CLAIMS

VS.

DIFFERENCES

WHAT value have claims of superiority unless there is a difference in formula or process to justify such claims?

Take cigarettes for example.

PHILIP MORRIS Cigarettes are *made* differently. In the clinic as well as in the laboratory, the *advantages* of PHILIP MORRIS have been repeatedly observed, repeatedly reported by *recognized authorities* in leading medical journals. Yes, PHILIP MORRIS *claims* superiority . . . *and that superiority has been proved.**

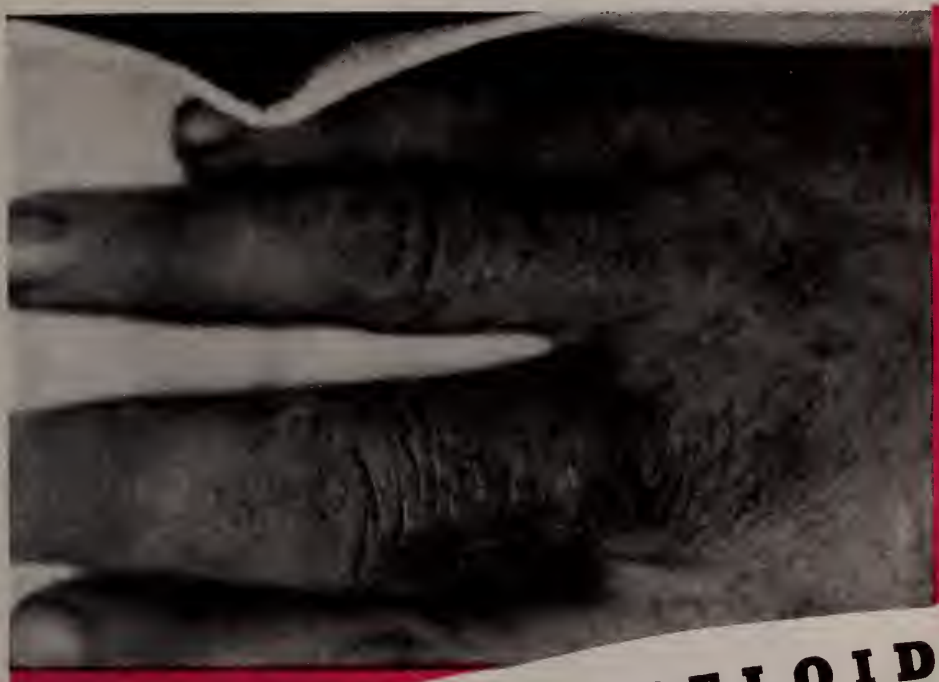
May we suggest that your patients suffering from irritation of the nose and throat due to smoking change to PHILIP MORRIS—*the one cigarette proved definitely less irritating.*

PHILIP MORRIS

PHILIP MORRIS & CO., LTD., INC.,
119 FIFTH AVENUE, N. Y.

**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

TO THE DOCTOR WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.



ERYSIPELOID
(Rosenbach's Disease)

Not to be confused with streptococcic erysipelas, this extremely painful, and sometimes even fatal infection is caused by Erysipelothrix rhusiopathiae. It is observed rather frequently among those brought into contact with animals and fish. Veterinarians, slaughterhouse-workers, butchers, farmers, bone-button makers, fish-handlers and cooks are most likely to contract the condition, which usually starts as an erythema at the site of primary infection, notably the fingers.

Now—WELL-TOLERATED TREATMENT WITH *Concentrated* ANTI-ERYSIPELOID SERUM
(PITMAN-MOORE)

HOW SUPPLIED

Pitman-Moore Concentrated Anti-Erysipeloid Serum is available in 10 cc. vials. Two to five cc. is usually adequate for the initial dose. In some instances repeated or increased dosage will not be necessary.

Since the disease in animals responds to sero-therapy, the unrefined anti-swine erysipelas serum was employed in human cases, with much success. However, this unconcentrated serum, in effective dosage, leads rather frequently to anaphylaxis and serum reactions.

REDUCED REACTIONS—To minimize this objection, Pitman-Moore Laboratories have developed a *concentrated* and *refined* antiserum for human use, in which the volume is reduced as much as 80%.

Complete information to physicians on request.

PITMAN-MOORE COMPANY

PHARMACEUTICAL AND BIOLOGICAL CHEMISTS

Division of Allied Laboratories, Inc., • Indianapolis 6, Indiana



BOTH ACUTE AND CHRONIC EAR INFECTIONS RESPOND TO TOPICAL CHEMOTHERAPY WITH *White's* OTOMIDE

a *stable* solution of carbamide (urea) 10% with sulfanilamide 5% in glycerin of unusually high hygroscopic activity. Anhydrous chlorobutanol 3%—a local anesthetic *that is therapeutically compatible with sulfonamides*—is included for its analgesic and antipruritic properties.

Therapeutic Advantages of Carbamide as Component of Otomide

1. Chemically debrides lesion by solvent effect on necrotic tissues.
2. Renders sulfanilamide effectively antibacterial even in the presence of pus.
3. Solubilizes sulfanilamide, effecting higher tissue concentration and increasing diffusibility through living and dead tissues.
4. Non-irritating.

Indications:

Local management of suppurative and non-suppurative otitis media, and of sulfonamide-susceptible infections of external auditory canal.

White's Otomide is available in dropper bottles of one-half fluid-ounce (15 cc.)—*on prescription only*.

PHARMACEUTICAL *White* MANUFACTURERS

LABORATORIES, INC.

NEWARK 2, N. J.

Wyeth
REG. U. S. PAT. OFF.



CONESTRON*

FOR MENOPAUSAL SERENITY

TABLETS (equine)

NATURAL CONJUGATED ESTROGENS

(0.625 mg. Estrone Sulfate)

ORAL THERAPY WITH CONESTRON provides safe, dependable control of menopausal symptoms and restores the patient's sense of well-being.

ORAL THERAPY WITH CONESTRON is relatively free from undesirable side effects.

ORAL THERAPY WITH CONESTRON is most desirable from the standpoint of convenience and time economy. CONESTRON TABLETS are supplied in bottles of 100 and 1000 tablets.

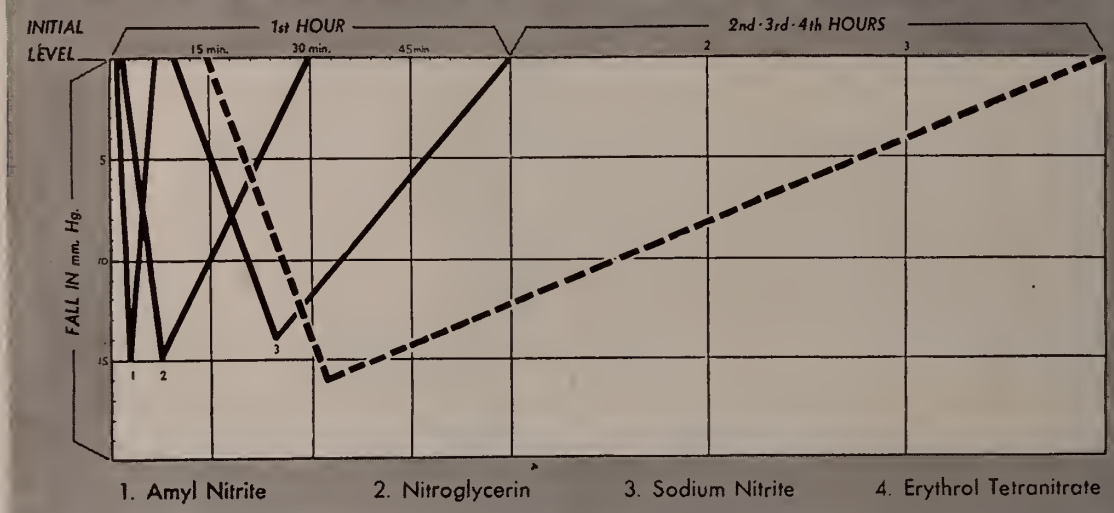
THE LATEST ADDITION TO WYETH SPECIALTIES

*TRADE-MARK

Wyeth

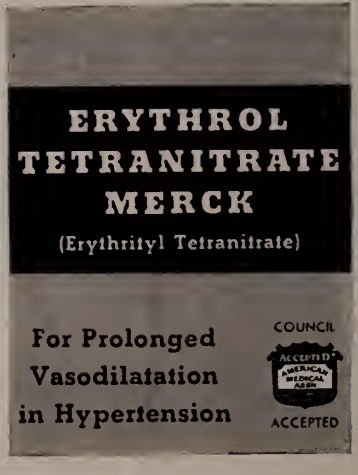
WYETH INCORPORATED • PHILADELPHIA 3 • PA.

PROLONGED REDUCTION OF HIGH BLOOD PRESSURE



Comparative effects of commonly used nitrites on systolic blood pressure in normal individuals. The action of Erythrol Tetranitrate Merck begins in 15 minutes and persists for three to four hours.

Treatment of arterial hypertension today is necessarily directed toward relief and not cure. When such measures as rest and dietary control have been unsuccessful, the employment of medical treatment is suggested. Among the various preparations available, Erythrol Tetranitrate offers the advantage of producing a reduction in blood pressure sufficiently prolonged so that administration three times daily may maintain the reduction. Erythrol Tetranitrate Merck may be prescribed over a protracted period with sustained effect. By dilating the peripheral arterioles, it tends to decrease not only the stress of excessive pressure on the arterial walls, but also to relieve the burden of the heart.



MERCK & CO., Inc. *Manufacturing Chemists* **RAHWAY, N. J.**



GAINING TWO AND LOSING ONE may be good checkers, but it usually is not sound therapy in peptic ulcer. Yet that is what may occur when an ordinary alumina gel reacts with gastric HCl to form astringent aluminum chloride. Efforts to relieve the resulting constipation may partially offset the healing effects of alumina therapy.

'GELUSIL'★ Antacid Adsorbent provides a specially prepared alumina gel which remains wholly unaltered upon contact with hydrochloric acid in the stomach. 'GELUSIL' Antacid Adsorbent forms a protective colloid which permits normal healing without producing constipation, acid rebound, or alkalosis.

Supplied as a gel, as well as in tablet form, 'GELUSIL' Antacid Adsorbent contains stable, nonreactive aluminum hydroxide and magnesium trisilicate . . . Bottles of 6 and 12 fluidounces. Boxes of 50, 100, and 1000 tablets.

'GELUSIL'

ANTACID ADSORBENT

★ *Trademark Reg. U.S. Pat. Off.*

WILLIAM R. WARNER & CO., INC., 113 West 18th Street, New York 11, N.Y.

In Indolent and Slow-Healing Wounds

When tissue stimulation is required to induce healing, Morruguent Ointment has proved of highly beneficial influence. Since it contains the unsaponified active principles of cod-liver oil in concentrated form, it is more powerful than cod-liver oil itself.

Morruguent Ointment accelerates liquefaction of dead tissue, and stimulates granulation and epithelization. It forms a protective, nonirritant coating—does not form an adherent coagulum—aids in the healing of burns, of pyogenic skin infections, of infected as well as noninfected wounds—and lessens scarring.



MORRUGUENT

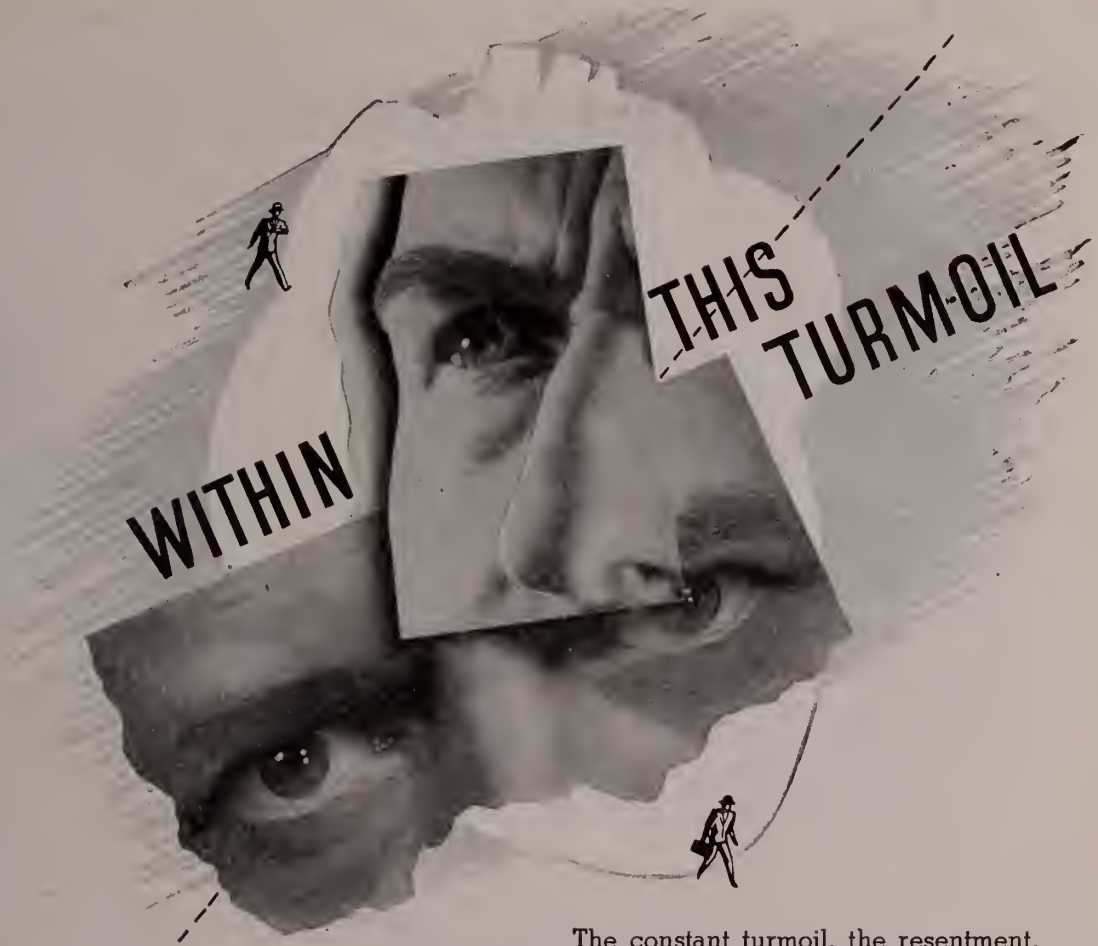


Apply directly to the lesion, cover with gauze, and bandage lightly if desired. Renew as often as necessary. Morruguent Ointment is supplied in 2-oz. collapsible tubes, and in 1-lb. and 5-lb. jars.

THE S. E. MASSENGILL COMPANY
Bristol, Tenn.-Va.

NEW YORK • SAN FRANCISCO • KANSAS CITY

SEMCO



The constant turmoil, the resentment, the inquietude of essential hypertension is a heavy and weary weight to bear. Relief without serious side reactions can be obtained in a newer symptomatic management with VERATRITE.

By widespread vasodilatation with marked improvement in arterial circulation Tabules Veratrite produce a calm, gradual fall in blood pressure, relieving the strain on the heart. Veratrite combines a BIO-ASSAYED Veratrum Viride with sodium nitrite and phenobarbital. Thus is provided a mild sedation, a prompt and prolonged hypotensive action within a wide range of therapeutic safety. Biological standardization of VERATRUM VIRIDE employs the Daphnia Magna Method, an Irwin-Neisler development. By employing the whole powdered Veratrum, assayed to uniform potency, the desirable rationale of Veratrum therapy is assured.

Dose: Administer two hours after meals. 1st Week: 3 to 6 tabules daily. 2nd Week: increase or decrease dose depending upon response. AVAILABLE in bottles of 100.

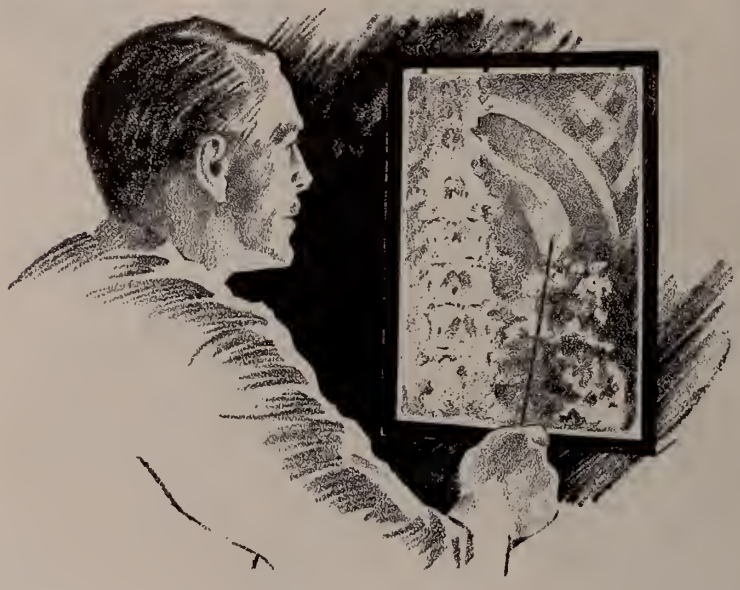
Veratrite

IRWIN, NEISLER & COMPANY Irwin SINCE 1885 NEISLER **DECATUR, ILLINOIS**

In both Obstructive and Toxic Jaundice

SORPARIN

(Ext. Sorbus aucuparia "McNeil")



Absorbed from the intestine, even in the absence of bile, Sorparin safely and successfully maintains plasma prothrombin in obstructive jaundice.

In toxic jaundice, Sorparin dispels the dyspepsia, shortens the course of the disease and stimulates the function of the liver cells.*

Sorparin is also indicated in hepatitis, chronic cholecystitis, postsurgical biliary states and chronic passive congestion of the liver.

Available in tablets, each containing 3 grains Sorparin. The suggested dosage is two tablets three times a day with a little water before meals.

Bottles of 100, 500 and 1000.

*DeLor, C. J. and Means, J. W.: Clinical Studies on the Berry of Sorbus Aucuparia, Rev. Gastroenterol., **11**:319-327 (Sept.-Oct.) 1944.

McNeil Laboratories
INCORPORATED
PHILADELPHIA • PENNSYLVANIA



"WELL, DOCTOR, I'D PUT THIS BABY ON DRYCO"

"His condition requires careful dietary supervision—with Dryco you can easily adjust the formula to meet his requirements."

Because Dryco offers the physician wide limits of formula flexibility, it is ideally suited to *special* feeding . . . besides being perfectly suited to *normal* cases. It may be prescribed with or without added carbohydrate . . . and may be employed in *concentrated* form also when indicated.

The high-protein, low-fat ratio of Dryco (2.7 to 1) assures optimum protein intake and minimal gastro-intestinal upsets from fat indigestion. In addition, Dryco contains adequate vitamins A, B_1, B_2, and D, plus essential milk minerals.

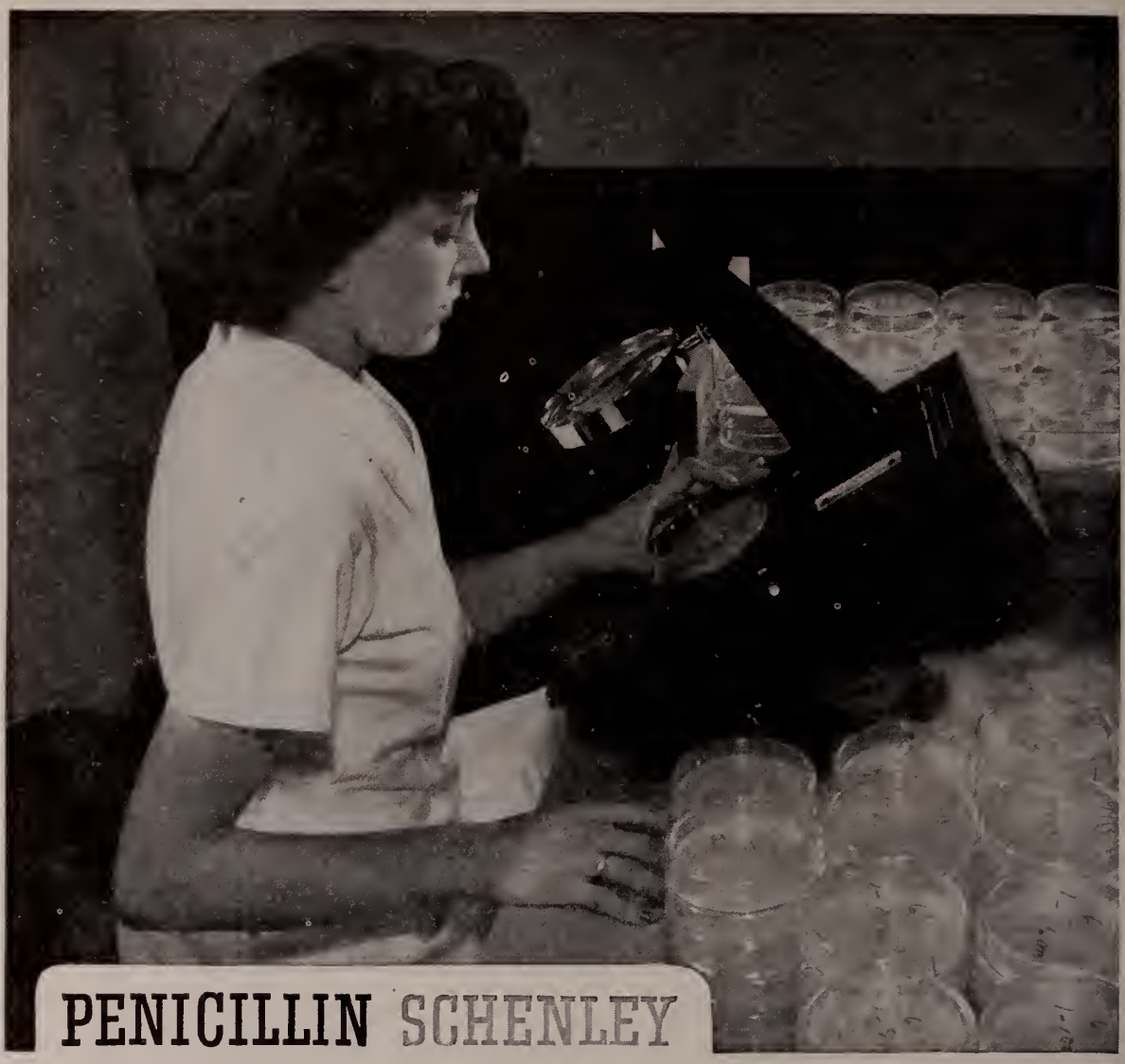
BORDEN'S PRESCRIPTION PRODUCTS DIVISION
350 MADISON AVENUE, NEW YORK 17, N. Y.

In Canada Write The Borden Company, Limited, Spadina Crescent, Toronto

DRYCO *is made from spray-dried, pasteurized, superior quality whole milk and skim milk. Provides 2500 U.S.P. units vitamin A and 400 U.S.P. units vitamin D per reconstituted quart. Supplies 31½ calories per tablespoon. Available at all drug stores in 1 and 2½ lb. cans.*

USE
DRYCO
THE "CUSTOM FORMULA"
INFANT FOOD





—the drug that gives new meaning to the word "control"

The penicillin which first attracted the attention of Alexander Fleming was an "occurrence of nature", with no control exercised over the conditions of its production. Production of pyrogen-free penicillin for the medical profession, however, is accomplished only by the most elaborate methods of control for insuring highest attainable productivity, potency, and purity.

Shown here is one of the many rigid controls exercised at the Schenley Laboratories. In this step, PENICILLIN SCHENLEY is being tested to insure standard potency. Such measures of elaborate control are your assurance that you may specify PENICILLIN SCHENLEY with the greatest confidence.



SCHENLEY LABORATORIES, INC.

Producers of **PENICILLIN** SCHENLEY • Executive Offices: 350 Fifth Avenue, New York City

When the RISK is great



WHEN the physician reaches a decision that conception would present an undue hazard to health, the "RAMSES"* Flexible Cushioned Diaphragm may be prescribed with confidence. The unique patented construction of the rim provides a wide unindented area of contact with the vaginal walls, plus a buffer against spring pressure.

"RAMSES" Flexible Cushioned Diaphragms are manufactured in gradations of 5 millimeters in sizes ranging from 50 to 95 millimeters. They are available on the prescription or order of physicians through recognized pharmacies.

ACCEPTED AMERICAN MEDICAL ASSN

Ramses

FLEXIBLE CUSHIONED DIAPHRAGM



A MARK OF Ramses DEPENDABILITY

*The word "Ramses" is the registered trademark of Julius Schmid, Inc.

Gynecological Division

JULIUS SCHMID, INC.

Established 1883

423 West 55 St. New York 19, N.Y.

Specific Action

TO PROMOTE FAT DIGESTION

When fat digestion is impaired due to deficient bile secretion, and when fatty foods prove intolerable in the absence of gallbladder involvement, Degalol—the original, chemically pure deoxycholic acid—offers noteworthy advantages.

A constituent of human bile, it is the fraction chiefly concerned with fat emulsification, promoting the digestion and absorption of ingested food fats and the utilization of the fat-soluble vitamins.

In the dosage required, Degalol exerts little or no choleretic influence. Thus it proves superior to ordinary bile salts which not only are less potent in their influence on fat emulsification, but—since they are required in higher dosage—produce side actions which are frequently undesirable. The powerful choleretic influence of the bile salts, for instance, is definitely to be avoided in catarrhal jaundice, though fat digestion and vitamin absorption are to be enhanced.

DOSAGE

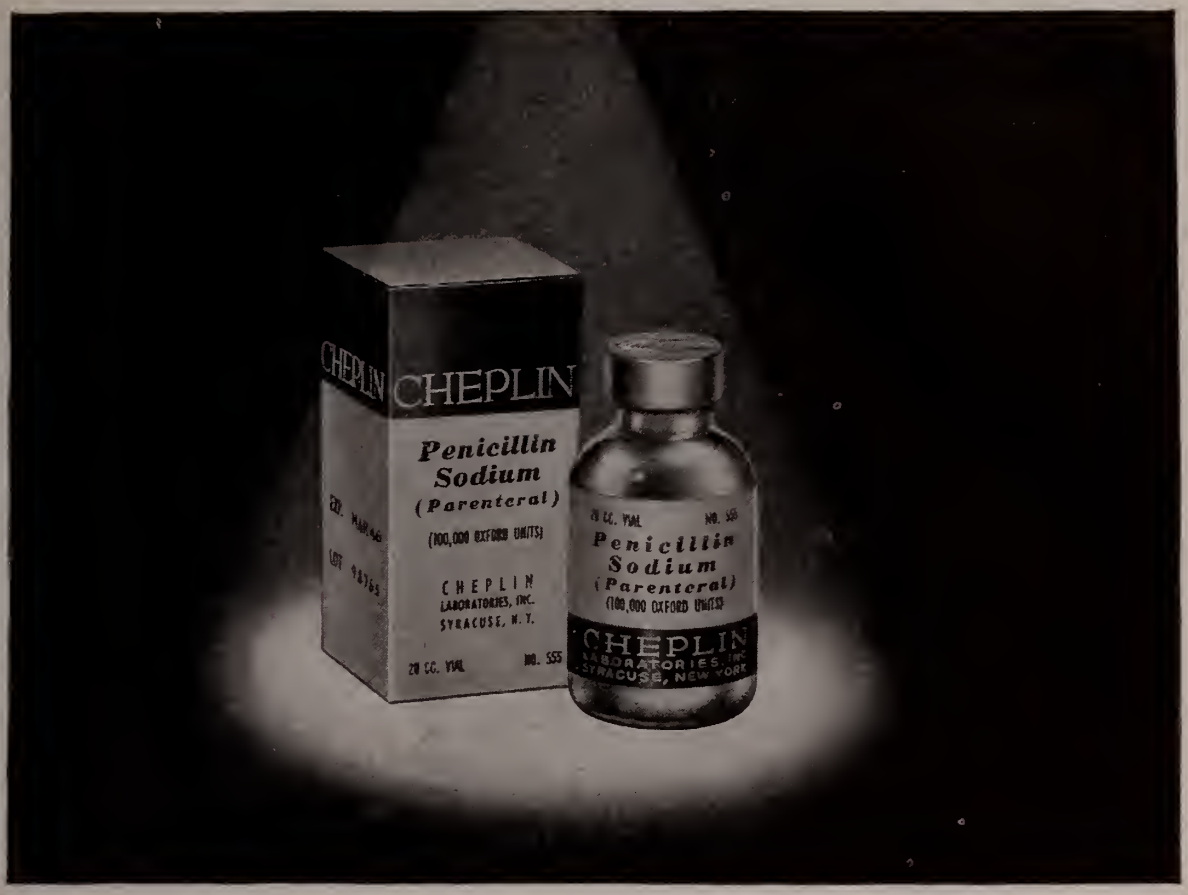
One or two 1½ gr. tablets t. i. d. Supplied in boxes of 100 sanitaped 1½ gr. tablets. Available on prescription thru all pharmacies.

When fatty foods lead to postprandial distress and epigastric pain, Degalol frequently proves specific. In suspected or frank deficiency of fat-soluble vitamins D, E and K and carotene, the administration of Degalol together with the vitamins is indicated.



CHEMICALLY PURE DEOXYCHOLIC ACID

Riedel - de Haen, Inc. • New York 13, N. Y.



POTENCY AND DEPTH OF COLOR IN PENICILLIN

Herwick, Welch, Putnam and Gamboa* offer two important conclusions regarding the possibility of irritation after intramuscular injection of penicillin. They are that:

1. An increase in potency in units per milligram of penicillin brings about a corresponding decrease in the pain produced, and
2. A correlation exists between the potency of penicillin and its light transmission.

When you employ Cheplin Penicillin in your own practice you will find it:

1. Uniformly high in potency per milligram, and
2. Markedly light in color.

Order Cheplin Penicillin through your physician's or hospital supply house.

*J.A.M.A. 127:74-76 (Jan. 13) 1945.

CHEPLIN
LABORATORIES INC. SYRACUSE 1, NEW YORK



Guiding Principles

in combating a common and stubborn cause of

LEUKORRHEA

Trichomonas vaginalis

In the treatment of trichomonas leukorrhea consideration should be given to extermination of the parasites, and to restoration of the normal vaginal flora.

Such a dual action is achieved through treatment with Devegan. Marked improvement is frequently observed within three or four days. The subsidence of the profuse, malodorous discharge is accompanied by a corresponding decrease of the intense local burning, itching and other discomfort. Even in chronic cases a cure may result in two or three weeks.

Devegan is applied in two forms: in powder and in tablets. The powder is insufflated into the vagina several times a week by the physician, while the patient is instructed to use the tablets at home. Later, when the discharge has been greatly reduced, the tablets alone are usually sufficient to complete the cure.

PAMPHLET GIVING DETAILED INFORMATION SENT ON REQUEST

Devegan Tablets are supplied in boxes of 25 and 250, each containing 0.25 Gm. of acetylaminohydroxyphenylarsonic acid.

Devegan Powder is available in bottles of 1 oz. and 8 oz.

WINTHROP

D E V E G A N

Trademark Reg. U. S. Pat. Off. & Canada

WINTHROP CHEMICAL COMPANY, INC.

Pharmaceuticals of merit for the physician

NEW YORK 13, N. Y. WINDSOR, ONT.



To ensure restful sleep, physicians have learned, through years of gratifying clinical experience, to rely on Allonal, the Roche hypnotic-analgesic. Its effect takes place smoothly and gently yet with sufficient forcefulness to insure the desired sedation and analgesia. Moreover, the use of Allonal is seldom accompanied by "hangover." A dose of 1 or 2 Allonal tablets—and the patient drops off into calm, refreshing sleep of normal duration which is followed by a bright, clear-headed awakening. Allonal assures the patient of a good night's rest. Allonal is available in boxes of 12 and 50 for your prescription.

HOFFMANN-LA ROCHE, INC., ROCHE PARK, NUTLEY 10, N. J.

Allonal 'ROCHE'


Coutlier

V-Day for the Doctor!



● "Good-bye, Doc—and thanks for everything!"

Yes, that's V-Day for the service doctor . . . victory in his war to *save* lives.

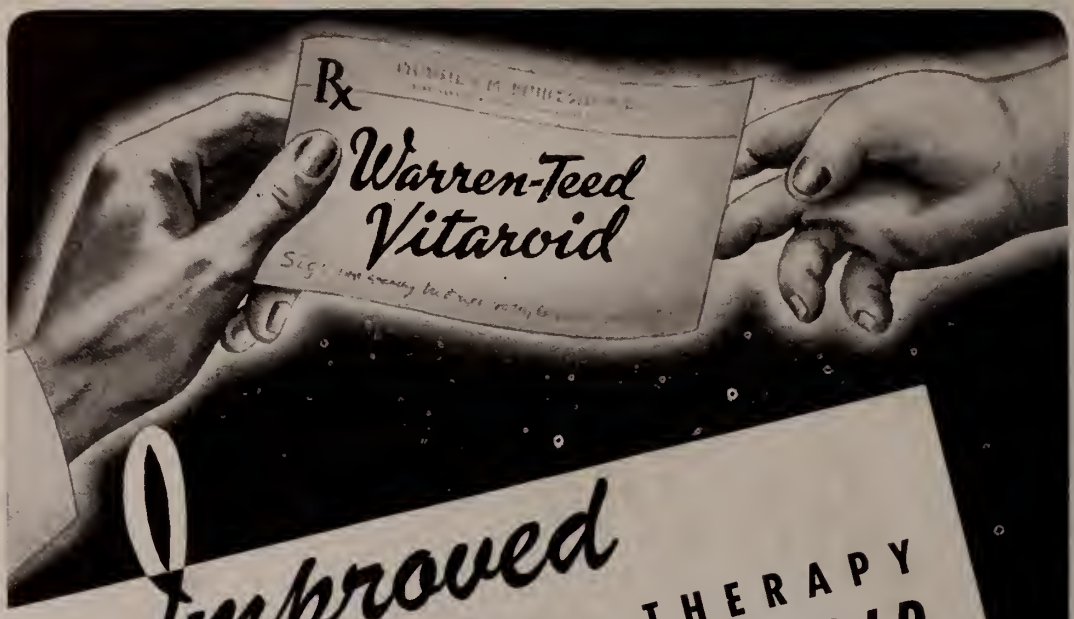
And doctor that he is—soldier too—he well knows how much a "smoke" can mean to a fighting man. He himself may find that same comfort and cheer in a few moments with a good cigarette. Very likely it's a Camel—for Camels are such a big favorite with fighting men—in O.D., in blue, and in *white*.



R. J. Reynolds Tobacco Company, Winston-Salem, N. C.

BUY WAR BONDS STAMPS

Tobaccos—Camels



Improved THYROID THERAPY WARREN-TEED VITAROID

Thyroid dosage alone is not enough — supplementary vitamin intake is also important, in the experience of many physicians. Vitamins A and C especially are consumed at a greatly increased rate. The seriousness of this depletion will be aggravated further by dietary restriction which reduces the vitamin intake. Prescribe Warren-Teed Vitaroid tablets for improved thyroid therapy — U.S.P. thyroid *plus* vitamins in a single tablet.

Each Warren-Teed VITAROID Tablet contains:

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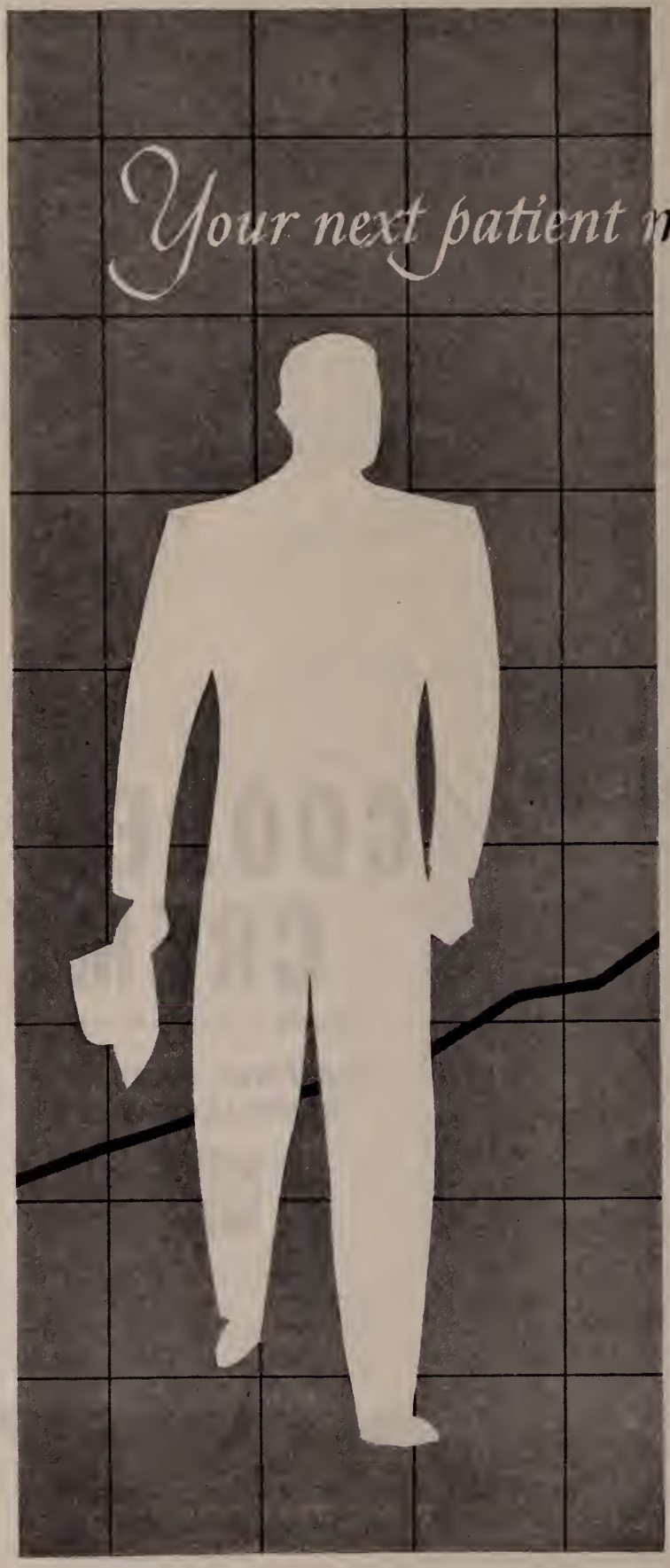
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*Blotner, H., and Hyde, R. W.: New England J. Med., 229:885, 1943.



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OH, BOY! JUST TWO MORE WEEKS

THINGS had looked pretty good for the North-Side Hornets until young Bill Wilkins broke his leg in the first scrimmage of the season. Bill was tough, but not so tough that his tibia didn't snap when twisted under the weight of three enthusiastic tacklers. Then followed days of hospitalization, with the inevitable cast and long hours of patient waiting. Now everything was to be all right, for only this morning Dr. Perry had said, "Just two more weeks, Bill, and you'll be as good as new." Bill knew that when Dr. Perry said "two weeks" he meant just that. All his life he had been taught to respect Dr. Perry and to rely on his judgment. It never occurred to him to question the doctor's decision.

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September, 1945
VOL. 88, NO. 3

The Illinois Medical Journal

Official Journal of the Illinois State Medical Society

EDITOR — Harold M. Camp. EDITORIAL BOARD — James H. Hutton, Chairman, Frederick H. Falls, Josiah J. Moore, Edwin M. Miller, Chauncey C. Maher, Harry S. Gradle, Harry Culver, Walter Stevenson, Raymond W. McNealy.

Editorials

"WE CARRIED THE TORCH"

Robert S. Berghoff, M.D., F.A.C.P.

President-Elect Illinois State Medical Society, Clinical Professor of Medicine Loyola University School of Medicine

Pearl Harbor Sunday struck a United States peaceful, quiet, and church-going, and roused it to instantaneous fury, complete unity, and ferocious efficiency. Our immortal President threw the switch, the wheels of the Government churned, and ships, jeeps, armament and aeroplanes all but clogged the runways. America overnight was at War, determined to win the greatest War in history. Industry, Labor, Capital, Inventive genius, and eleven million of its citizenry, men and women, surged to arms.

Peace-time America's medical profession consisted roughly of one hundred and thirty thousand men and women — or again roughly, 1/10 of one per cent of its citizenry — small, but sufficient to give our country the grandest health record, lowest morbidity, and most envied longevity in all the world. The Surgeon General called for doctors and like sheep on our western plains they stampeded their way into their country's service. Internes left an incompleted hospital service; young men and women with a budding practice: middle-aged practitioners with valuable experience, health, vigor and ambition. Men of fifty tightened their belts to hide the tell-tale paunch of years. Men in their fifth and sixth decades of life, grey haired, bald, with national and international reputations, left children and grandchildren to give freely and gladly to their country which had given them so much.

Into the armed services they thronged — ten, twenty, thirty, forty thousand strong. Like the Minute Men of Lexington they rushed forward to hold the line! And what were they able to give to the eleven million of gallant men and women fighting for Liberty and Democracy? The sulpha drugs; penicillin; newer methods of surgery; the latest in diagnostic skill? Aye and more —vastly more! They gave their life's blood, countless hundreds of them, on the battlefields, in the air and on the seas, but they gave to this vast army of ours again the lowest death rate and highest recovery rate of any army in history.

In the meantime the medical profession at home, depleted not only by forty per cent, but by the most virile forty per cent, carried on with its routine civil practice. Men and women in our profession found physically unfit for the rigors of military service buckled down to double duty — their own and that of a departed professional buddy. Old men, sixty, seventy and eighty years old, came back into active practice once more. Out came too, the coughing, sputtering old automobile with its worn tires; but armed with a "C" sticker it traveled the country roads and the city streets by day and by night.

Throughout the land they chanted the slogan,

"Carry the Torch." They took their food and their sleep as they found it, wiped their bleary eyes, grinned and said: "It won't be for long. The youngsters will be along soon. 'Carry the Torch.'"

The most disturbing note to the "Oldsters" was not the course of the war — the German war was won, the Japanese practically so. Another attack was in the offing — a legislative one. The United States of America, which had raised two hundred billion dollars without even a disturbing economic ripple, to wage the most stupendous and successful war in history, was now concerned about the ability of its citizenry to meet its obligations, if and when it needed medical aid. The Murray-Wagner-Dingell Bill, up for consideration, was about to change the entire complexion of the practice of medicine. And the Oldsters were confused, depressed and concerned. How could they "Carry the Torch" for the Young Uns on this vital issue?

Some of the Young Uns had given their lives in France, Germany, Okinawa, and far distant places, and the remaining thousands were plenty occupied taking care of the sick and wounded. And yet the old slogan was there, "Carry the Torch." So the Oldsters scratched their grey and bald heads, and as rapidly as possible organized throughout the land, in their various and separate states, "Voluntary Prepayment Plans for Medical and Surgical Services," and "Prepayment Plans for Hospital Care," to meet the needs of the vast number of men and women of moderate means. And they worked as busily as ants building their house, to offset a dangerous and pernicious national program of health control. "Carry the Torch." "Carry the Torch!"

And now the Oldsters of the medical profession of these United States make this homely plea: "Mr. President of the United States, Mr. Senator and Mr. Representative, if you please:

"We, the old and physically unfit members of the medical profession of the grandest country in all the world, we who have 'Carried the Torch' these past four years since Pearl Harbor, we beg of you, don't legislate our forty-five thousand 'Youngsters' who are still on the battlefields out of the type of practice of medi-

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cine they left and loved, wait until they come home to discuss this with you. In the meantime if our plan of voluntary prepayment seems to you learned gentlemen inadequate, if it does not reach quite all of our citizens, subsidize that minor percentage. The cost would be so small compared to what we have become accustomed to — and wait please, until we, your medical profession are once again a united 130,000 strong, so that we 'Oldsters' may in truth be able to strut, grin, hold up our chins, and as we clasp the hands of our Young Uns be able to say: 'We Carried the Torch.'"

Chicago Medical Society Bulletin, Aug. 25, 1945

AND NOW — RECONVERSION!

President Truman announced on August 14th that Japan had accepted the demand of the allied nations for unconditional surrender, and that the war in the Pacific was at an end. Since this announcement was made, Japanese envoys have received the terms of surrender at Manila and General MacArthur has planned to enter Japan. It is generally believed that the dropping of the two atomic bombs on Japanese cities brought the war lords of that nation to the firm belief that they had lost the war and there was no need to see their country completely annihilated.

With the sudden ending of the war, efforts are already being made for the reconversion period. Each day various government agencies are making announcements which appeal to the public — the lifting of gasoline rationing, the removal of restrictions on many other essential commodities.

Appeals have been filed by a number of state medical societies for the release of physicians who have been in service. A prominent Congressman has just announced that when Congress reconvenes he will promptly introduce a bill asking for immediate release of many medical officers to go back into civilian practice. Numerous problems have already arisen in this connection and many more will come before us in the near future.

There are, as everyone knows, many thousands of casualties being cared for in Army and Navy Hospitals where they are working with peak loads. Most of the European casualties have been brought home, and many more from the South Pacific are arriving on hospital ships daily. Their care will necessitate holding many capable medical officers in service for some time to come.

It is obvious that many medical officers will be required to give adequate care to the vast armies of occupation, and perhaps to give some civilian care in those countries which have a marked shortage of physicians as a result of the war. Thousands will no doubt be retained to work in the many Army and Navy Hospitals for many months after peace is formally declared.

It is hoped that within a relatively short time many of the older medical personnel, those who have been in service for a longer period of time will be gradually released and permitted to resume caring for patients in civilian life. With approximately 4,500 Illinois physicians with our armed forces there has been a shortage of physicians in many communities. The death rate among the older physicians who have been carrying on has been unusually high. In a number of Illinois counties during the past year all doctors in practice are well over the age of 50, and in one county there has been only one physician under the age of 70.

During the war which has just ended there have been many physicians relocated in Illinois. Some of these men had previously retired after a long professional life, then when the call came for volunteers to serve in a critical area, they have once more entered practice in a new field. Full credit should and will be given to all those men who gave up a lucrative practice and responded promptly to the call of the government for physicians for our armed forces, but future medical historians will find many interesting stories of the work done by the older men who had to carry on under trying circumstances, many times when they themselves were not physically able to assume such a heavy responsibility.

As our physicians return from the services, no doubt many will want to take refresher courses before resuming civilian work. Many others who have not been in private practice will want additional post graduate courses, and then a good location. The Bureau of Information established within the American Medical Association to aid these men in every way possible, will give information to them, and the respective state medical societies throughout the country will likewise be ready to assist.

Information has been received and placed on

file relative to the 102 counties in Illinois. These records are being supplemented constantly to bring the data completely up to date. Medical schools, Post Graduate Schools, and many medical societies are arranging refresher courses and information concerning these plans will be available within a short time. This material will be published in the Illinois Medical Journal.

Many letters requesting information have been received in the office of the state society secretary. Each has been answered promptly. We recently learned of an unusual case in Illinois where a father nearing the age of 90 has been maintaining the office and the practice formerly carried on by himself and his son who has been in service for more than three years. Another well known instance is a prominent Illinois physician of 80 who is conducting the office formerly occupied by four physicians, two of whom are in service and the third passed on recently. This highly capable man who has been practicing more than fifty years, is still doing good surgery, obstetrical work and general medicine, and spending six busy days each week in his office.

Such examples (and we know of many other similar cases in Illinois) should be publicized by the press and brought to the attention of our legislators to show that such conditions could not possibly prevail under a federalized plan for providing medical care. Likewise we believe it entirely unfair to the many thousands of American physicians serving their country to even consider the advisability of changing the basic form of medical practice at a time when they are unable to express their desires on that important subject.

It seems logical to believe that our legislators will give serious consideration to the desires of the men in uniform who have cared so capably for the hundreds of thousands of casualties resulting from combat in the many theaters of war during the past three and one-half years since the assault on Pearl Harbor.

IMPORTANCE OF MEDICAL RECORDS OF SERVICE RENDERED VETERANS

"A joint resolution urging physicians and dentists to maintain records of services rendered to veterans of the present war was introduced in the Wisconsin Legislature, and subsequently publicized in the Wisconsin Medical Journal. The resolution is as follows:

STATE OF WISCONSIN
No. 53, A. 1943
A JOINT RESOLUTION

Urging physicians and dentists to maintain records of service rendered to veterans of the present war

WHEREAS, It is essential to the recovery of federal war compensation by veterans of the present war that a given disability be shown to have resulted from and in connection with the military service of the claimant, and

WHEREAS, It is also essential to proof of such service-connected disability that all treatment records kept by a physician or dentist of the claimant be available to military and federal authorities, and the absence of such a record may defeat the bona fide claim of a veteran; now, therefore, be it

Resolved by the assembly, the senate concurring, That the state board of health, state board of medical examiners, the state board of dental examiners, and the several professional societies be requested forthwith to ask that all practicing physicians and dentists ascertain, so far as possible, whether patients are now or are on any subsequent date veterans of the present war, and that in the case of each such veteran his case history be preserved for at least 6 years after the date of the last professional service is rendered by such physicians or dentist. Be it further

Resolved, That each of the above boards and professional societies be further requested to contact all of their respective licensees and members at least once a year for the balance of the war, and at least once each year for the first 6 years following the war, so as to remind all such persons of the importance to the war veterans of preserving such professional records: and be it further

Resolved, That duly attested copies of this resolution be transmitted forthwith to such boards and professional organizations.

(Signed) CONRAD SHEARER
President Pro Tempore of the Senate
(Signed) LAWRENCE R. LARSEN
Chief Clerk of the Senate
(Signed) VERNON W. THOMPSON
Speaker of the Assembly
(Signed) ARTHUR L. MAY
Chief Clerk of the Assembly

This resolution was introduced by Assemblyman Lyall T. Beggs of Dane County, a veteran of the first World War and Past Vice-Commander of the American Legion. It will be printed periodically in The Wisconsin Medical Journal during the next several years.

Physicians and dentists in Illinois and elsewhere, should by all means keep adequate records of all services rendered to veterans of World War II, as well as for the care of all other patients. It is especially essential in the cases of former service men that these records be retained over a period of years in order that the veteran may be able at a later date to establish service-connection for the disabilities and receive the compensation to which he is entitled.

We therefore desire to urge that Illinois physicians keep this important matter in mind and be more meticulous in procuring all essential information and recording it so that adequate records will be available over a period of years.

WE SALUTE OUR MEMBERS IN SERVICE

From time to time since the outbreak of war claims have been made by various county medical societies regarding the per cent of their membership in military service as compared to other societies. For the information of our readers, we are, therefore, publishing some statistics on this subject.

It is interesting to note that 40 and more per cent of 11 of our societies are serving with the armed forces. The following societies appear in this group and deserve special recognition:

Perry	53%
Jackson	50%
DeWitt	50%
McLean	47%
Richland	46%
McHenry	46%
Tazewell	44%
Massac	42%
Shelby	40%
Logan	40%
Boone	40%

At the present time 10 of our county societies have a membership of over 100, and each has contributed between 26 and 37 per cent of its membership to the service. Lake County has made the outstanding contribution in this group, with 37 per cent of its membership in service, followed closely by Kane and Sangamon, each having contributed 36 per cent.

We wish to pay special tribute to Perry County for having 53 per cent of its membership in the service. It is interesting to note that this county has the highest physician-population ratio of any county in the state, according to the records of the Procurement and Assignment Service. One town in the county which formerly supported six physicians is now being served by only one man, although it is hoped that one physician, who is now hospitalized, will be able to resume his practice at an early date and that a second will be released from military service.

The following listing of county societies shows its total membership, members in service and per cent in service. In listing this data we have given credit to the members who have served at one time or another since the outbreak of war, but who have been honorably discharged and are again in civilian practice. We invite corrections to this data from our county society secretaries if discrepancies are noted.

This list considers only the members of the Illinois State Medical Society and the many non-members in service are not included in the list. The members of the Chicago Medical Society in Service are likewise missing in this report.

	Membership	Number in Service	% in service
Adams	60	19	32
Alexander	16	3	13
Bond	6	0	0
Boone	15	6	40
Bureau	34	10	29
Carroll	14	1	7
Cass	18	7	39
Champaign	96	30	39
Christian	26	8	31
Clark	12	2	17
Clay	11	3	27
Clinton	14	3	21
Coles-Cumberland	39	7	18
Cook	3528	1746	31
Crawford	14	2	14
DeKalb	36	14	39
DeWitt	16	8	50
Douglas	21	6	29
DuPage	93	28	30
Edgar	16	3	19
Edwards	7	2	29
Effingham	17	5	29
Fayette	8	2	25
Ford	16	5	31
Franklin	25	8	32
Fulton	30	8	27

	Member-ship	Number in Service	% in service
Gallatin	4	1	25
Greene	14	3	21
Hancock	17	2	12
Henderson	31	3	33
Henry	44	16	36
Iroquois	25	8	32
Jackson	32	16	50
Jasper	6	2	33
Jefferson-Hamilton	28	6	21
Jersey	6	2	33
JoDaviess	11	0	0
Johnson	3	0	0
Kane	157	56	36
Kankakee	63	23	37
Knox	41	11	27
LaSalle	97	27	28
Lake	104	38	37
Lawrence	10	3	30
Lee	29	10	34
Livingston	36	10	28
Logan	27	11	40
McDonough	30	7	23
McHenry	37	17	46
McLean	89	42	47
Macon	87	17	19
Macoupin	30	7	23
Madison	112	34	30
Marion	41	15	37
Mason	13	5	38
Massac	12	5	42
Menard	7	0	0
Mercer	11	3	27
Monroe	8	2	25
Montgomery	19	6	32
Morgan	47	13	28
Moultrie	8	3	38
Ogle	23	7	30
Peoria	198	66	33
Perry	15	8	53
Piatt	12	4	33
Pike	15	5	33
Pope-Hardin	2	0	0
Pulaski	4	0	0
Randolph	20	5	25
Richland	13	6	46
Rock Island	100	29	29
St. Clair	126	37	29
Saline	29	8	28
Sangamon	143	52	36
Schuyler	7	2	29
Shelby	20	8	40
Stephenson	41	11	27
Tazewell	34	15	44
Union	15	2	13
Vermilion	82	21	26
Wabash	12	2	17
Warren	23	4	17
Washington	11	2	18
Wayne	11	4	36
White	11	1	9
Whiteside	32	9	28
Will-Grundy	112	29	26
Williamson	26	5	19
Winnebago	174	56	32
Woodford	13	2	15

SEEK 12000 MEDICAL AND DENTAL STUDENTS

With the nation facing a serious shortage of doctors and dentists in the post-war period, Paul V. McNutt, chairman of the War Manpower Commission, has announced plans to enroll immediately 12,000 students for medical, dental, pre-medical and pre-dental school courses beginning this fall from among veterans now being discharged from the armed services.

Mr. McNutt said surveys show that even if medical school enrollments, admissions and graduations had been maintained at levels prevailing before recent changes in Selective Service policies there still would have been a post-war shortage of thousands of doctors and an even severer shortage of dentists.

"Unless we move quickly and successfully to wipe out the gaps torn in the ranks of the medical and dental professions by the exigencies of war, America will be denied essential security in terms of national health," Mr. McNutt said.

The situation is so severe that some medical schools will not fill any substantial part of their first-year classes beginning next month, he added.

With a goal of 8,000 students for medical and pre-medical schools and 4,000 for dental and pre-dental schools, the War Manpower Commission, with the cooperation of the Army, the Navy, the Veterans Administration and the medical and dental professions, will place the story of the opportunities in the medical and dental professions before men in the armed forces who are scheduled for discharge in the near future.

Information concerning these opportunities will be included in various publications reaching soldiers, sailors and marines in various parts of the world, with an explanation of the financial assistance available under the G. I. Bill of Rights. In addition, more comprehensive information will be furnished counsellors and education officers in assembly areas.

The medical and dental professions will supply lecturers for the counsellors in separation centers so that professional students returning from service with the armed forces can be properly advised of the opportunities in medicine and dentistry. Counsellors at separation centers will be supplied with more detailed information, including the prerequisites of medical and dental schools.

At all seperaration centers the most likely candidates for medical and dental and pre-medical and pre-dental schools will be screened on the basis of their qualifications and expressed interest.

Educational information will also be supplied to interested and qualified prospects through veterans employment representatives in local offices of the United States Employment Service, the Veterans Administration and local Selective Service Boards.

While nearly 40 per cent of the active practicing physicians of the United States are now in the armed forces, the chief concern at present is not only the wartime supply of physicians and dentists for civilians, but also the supply of physicians and dentists for veterans and the peacetime armed services. As a consequence of the war, Mr. McNutt said, many more physicians will be needed than were available before the war. Present estimates are that a peacetime army will require 10,000 physicians, a peacetime navy about 5,000 and the Veterans' Administration about 15,000.

Furthermore, the widespread destruction of hospitals and medical schools and physician casualties in the liberated countries of Europe and China will require the aid of unknown numbers of physicans from the United States, he said. The number of physicians in the armed forces of the United States killed or incapacitated by the war, and requiring replacement, together with the high mortality among over-worked physicians who remained at home during the war are other known factors whose effects cannot be accurately predicted.

On the basis of the information now available, Mr. McNutt said, it is conservatively estimated that about 35,000 additional doctors will be needed. But a survey by the American Council on Education and the Office of Scientific Personnel of the National Research Council has indicated that less than half of this need will be met.

A similar situation prevails in the field of dentistry except that the supply of dentists was already falling rapidly before the war. From 1910 to 1940, the number of graduates in dentistry decreased 23 per cent while the population of the United States increased 42 per cent. The preponderance of the older age groups is shown by the fact that of the dentists practicing in the United States in 1940, 25 per cent had been graduated before the year 1910. This meant that the dental profession at the beginning of the war was numerically inadequate to care for the health needs of the American people, Mr. McNutt said. The demands of the military forces reduced the number of dentists available to civilians by about a third.

As a result, the health care now being given the civilian population by those in private dental practice is principally emergency work. There has been untold neglect of the oral health of all the people, especially children, which is piling up a backlog of oral defects for which the dental profession must assume responsibility, Mr. McNutt said.

Unless the search for dental students among veterans is successful, it is unlikely that many dental schools of the country will be able to fill freshman classes this year, Mr. McNutt said. Surveys indicate that instead of the several thousands needed, actual freshman enrollment will not exceed a few hundred. The success of the new program is therefore essential to the health and welfare of the American people both at present and in the years to come, for without additional medical and dental personnel there can be no assurance of the maintenance of American standards of health, Mr. McNutt said.

IMPORTANT

Send changes of address to 30 N. Michigan Ave., Chicago 2, Illinois, enclosing label from a copy showing your old address. Changes received after the 1st of the month will not go into effect until the following month.

Medical Economics

The Medical Economics Committee — Chauncey C. Maher, Chmn., 6 North Michigan Avenue, Chicago, Edwin S. Hamilton, V. Thomas Austin, Emmet B. Bay, Jay McDonald Milligan, Jacob M. Mora, George Halperin, Marie Wessels, Thomas C. Browning, Roland R. Cross, Milton E. Bitter, Edwin F. Hirsch, Ford Hick, Lt. Col. MC, William J. Bryan, John R. Vonachen.

MEDICAL CARE OF INMATES AT COUNTY POOR FARMS

Providing adequate care for the unfortunate poor has been a governmental problem since the organization of nations. Our great United States has the reputation of providing better care for these unfortunates than any other nation of the world. This perhaps is not unnatural since our standards of living are higher, and even the poorest kind of care in this country might measure high by other standards. We, therefore, should measure adequate care in this country compatible with sound economy and common decency. On the other hand, such care should not be made so attractive as to place a premium on indigency.

There necessarily are wide variations of such care throughout this nation of ours, since most states have by law charged the various counties with providing for their own paupers.

Chapter 107 of the 1941 revised statutes sets forth the laws under which the various counties may provide care for these poor people and delegates broad power to the county board of supervisors. Under this act a county farm and home for the poor may be operated, or special grants or other provisions for individual care may be made.

That the law considered this problem to be at least partly medical is evidenced by the fact that it empowers the board to employ a county physician whose duty it is to administer to the sick inmates. Further evidence of this is implied in Article 32, which requires the keeper of such poor farms to "keep an account of each person showing his name, admission and discharge dates, place of birth, and whether dependency was due to idiocy, lunacy, intemperance, or other causes." The county board, therefore, has almost unlimited power as to the type and kind of medical care and supervision furnished for the inmates of each county home.

It would not seem to be unusual that such care would vary throughout the state. Such factors as population, wealth, type of political officers, interest of the medical profession, social mind of the community, and last, the extent of the problem, affect these variations. The rural problem is distinctly different from the urban, and for this reason the Cook County data will be given separate consideration. A few county homes in the rural districts were personally inspected. These are treated separately but are not all mentioned specifically by name. Except for the personal visits and letters from Dr. J. M. Aronson, medical superintendent of Cook County Infirmary, and a telephone interview with Mr. Otto Wander, Supervisior, Oak Forest Service, the information contained in this paper was obtained largely through the courtesy of the Illinois Public Aid Commission from data collected by them in November, 1944.

Of the 102 counties in the state, only 70 are maintaining county homes for the poor. The total population of these homes at the time of the census was 4588. There is a probable capacity of 8639. The factor of over-crowding does not seem to be a health problem to any large degree. No evidence of such was noted in any of the homes visited. The population of each home varies from as low as two to as high as 2496 (2210 in Cook County Infirmary alone), and vacancies vary from none to as high as 3230 (Cook County). Twenty-seven counties have a population of ten or less. This undoubtedly increases per capita costs. Indeed, some counties

have recently discontinued their homes and either provided care in private homes or in other neighboring counties still maintaining infirmaries.

Most inmates are between the ages of sixty to seventy-five. The law prohibits the admission of children of seventeen and under, although temporary quarters may be provided until permanent placement is arranged. The same may be said of the insane. There is a predominance of men, with a ratio of ten or fifteen men to one woman, most males are single, widowed, or divorced. Many are alcoholics.

Inmates may be classified into three main groups:

1. Ambulatory — workers and non-workers. All are able to dress themselves and walk to their meals.

2. Ill patients — those requiring special nursing care or hospitalization.

3. Bed or infirmary cases — tidy and untidy. In this group are found the mildly senile psychotics, paralytics, and cripples.

Medical attention is provided by the county physician employed on a yearly basis with an annual salary, usually paid monthly. Such salaries vary widely. In only three counties was medical cost determined, and in these not too accurately. In only twenty-four down-state counties was it possible to obtain any very definite information about medical care. Hospital wards or county hospitals are provided in eight counties, which, under certain circumstances, receive patients other than inmates. In six other counties, hospitals or wards are provided for inmates only. One of these, a separate building, has been closed for the past two years because no registered nurse is available. Another has provisions for four or five tuberculous patients. (Such patients should be sent to sanatoria.) Other infirmaries apparently arranged for hospitalization only in emergencies, and then in private or general hospitals in the county seat.

The wide variation of medical costs can best be illustrated by comparing two counties which were visited. In one of these counties the manner in which medical care was provided was a bit unusual and probably resulted in a better service to the patient. This home, which has a population of twenty-three men and two women, has no hospital ward. Patients were allowed to select their own physician, provided the distance traveled was no greater than that from the county seat to the county poor farm. Arrangements had been made with the medical profession of this county to make similar charges. All bills were paid monthly, and all patients were hospitalized at the nearest hospital at rates prearranged by the county poor farm and the hospital. The superintendent of the home stated that the monthly physicians' fees ranged from $75 to $78 and that medicine and hospital costs averaged about $25 per month. He further stated that no hospital care was denied any patient when requested by the physician. The medical per capita cost of this home was $4 per month. All medical care was charged to the county budget and not to the individual townships, but admissions were made upon the approval of the township supervisors.

In another home visited there were thirty men and six women with seventeen vacancies. Admissions were made in a similar manner by approval of the township supervisor, and all medical and nursing care was charged to each township except the county physician's salary, which was $200 per year. Each township allowed an additional one dollar per day for bed patients requiring extra nursing care. The county physician was called by the superintendent when necessary. About twelve calls were necessary per year. Medicine is purchased on prescription and charged to each township. The tendency was to protect the doctor and call him only when the case was urgent. Assuming that $160 was spent on hospital care and medicine, this would make a cost of 83c per month per patient as compared with $4 of the county just described.

Of the counties providing hospital divisions only one was visited. This was Winnebago, which has a separate building from the home but connected with it. The chonically ill bed patients, psychotics, cripples, etc., are not housed in the hospital. Consequently, they are not visited daily but only upon request of the superintendent of the home. There are sixty beds available for hospital cases and twenty-two available for contagion. These latter beds are paid for on a private-patient basis by the individual occupying them or by the township. This hospital is operated under the supervision of the county superintendent, but specifically by a supervising nurse. The medical staff is headed by a county physician who is appointed by the board of super-

visors and receives an annual salary. He spends approximately fifty per cent of each day at the hospital, besides caring for the ill at the county jail and such other services as may be required outside of the hospital. When possible to obtain, he has a resident and one intern. In addition to this, there is an unpaid visiting staff of twenty doctors from Rockford. No accurate per capita medical cost is available from this county.

The Oak Forest Infirmary, which is the county home of Cook County, has a somewhat similar but more extensive plan. This institution cares for 2210 inmates, besides about 350 or 400 tuberculous individuals. The tuberculous are cared for in a separate building and have a separate medical staff of their own which makes this part of the infirmary almost a separate institution of itself although it is financed under the same general management. The Oak Forest Infirmary has a general superintendent and a medical superintendent. General medical and surgical care, including emergency treatment, is provided in hospital wards for in-patients. An out-patient department is also maintained for other patients who are not hospitalized. The staff consists of a resident physician, an assistant resident physician, one senior physician, and seven junior physicians. Besides this there is a visiting staff which consists of ten men who cover the fields of dentistry, radiology, syphilology, surgery, cardiology, pathology, neuro-psychiatry, gynecology, and eye, ear, nose, and throat. The visiting staff members average about one visit per week per man and are paid by the visit. The regular employees are paid on a monthly basis. Besides the medical staff there are 270 employees, including fourteen graduate nurses, two orderlies, seventy attending nurses, one anesthetist, one laboratory technician, one x-ray technician, one druggist, one assistant druggist, one dietitian, and three assistant dietitians. The average cost of medical care in this institution was not obtained; but since the combined Oak Forest institution operates on an annual budget of $1,406,145.42, it would seem that the total per capita cost for sustenance, clothing, and medical care would be in the neighborhood of about $500 per year.

From the brief study it is believed that all of the county farms provide good housing, good clothing, and ample well-balanced meals for their inmates. In the homes which were visited, good sanitation was noted, and it may be presumed that his prevails universally throughout the state. There is, however, a wide variance in the type of medical care provided in the different county homes. This is evidenced from the information obtained through the Illinois Public Aid Commission, as well as from the personal inspections which were made. Some of the counties furnish practically no hospital facilities, and the patients receive medical care only in emergencies.

This study is by no means complete, and no conclusions as to the adequacy of medical care are made. Nevertheless, there is sufficient information available to warrant further and more complete investigation of this problem.

COUNTY HOMES IN OPERATION

November 25, 1944

County	Inmates	Capacity
Adams	32	75
Brown	3	15
Bureau	42	100
Calhoun	3	25
Carroll	26	31
Cass	8	18
Champaign	41	90
Clark	4	13
Coles	20	40
Cook	2,496	3,230
Crawford	7	30
DeKalb	47	80
DeWitt	12	30
Douglas*	3	21
DuPage	47	47
Edgar	2	20
Fayette	13	25
Ford	11	35
Franklin	12	21
Fulton	32	60
Greene	7	20
Hamilton	6	8
Hancock	28	40
Henderson	2	20
Henry	20	80
Iroquois	16	60
Jackson	6	15
Jersey	3	25
JoDaviess	2	10
Kane	127	190
Kankakee	21	60
Knox	39	100
Lake	66	90
LaSalle	130	275
Lee	25	49

*To be discontinued March 1, 1945

County	Inmates	Capacity
Livingston	39	70
Logan	6	40
McDonough	11	60
McHenry	60	85
McLean	40	120
Macon	60	100
Macoupin	28	68
Madison	97	130
Menard	26	26
Mercer	15	40
Monroe	23	30
Montgomery	12	25
Morgan	10	76
Moultrie	9	15
Ogle	36	53
Peoria	82	270
Piatt	8	50
Putnam	2	15
Randolph	9	25
Rock Island	38	80
St. Clair	159	300
Saline	5	16
Schuyler	7	30
Scott	3	25
Shelby	6	25
Stephenson	25	90
Vermilion	100	137
Warren	23	100
Wayne	5	14
White	8	100
Whiteside	25	65
Will	90	91
Williamson	9	12
Winnebago	114	176
Woodford	9	32

NUMBER OF INMATES — 4,558

PROBABLE CAPACITY — 8,639

NUMBER OF COUNTY HOMES — 70

ADDENDA

Cook County — Oak Forest Infirmary

No. of Inmates

Infirmary 2239
T. B. Hospital 257

Maximum Capacity

Infirmary 2780
T. B. Hospital 450

County	Hospital Department and Kind of Patients Received
Carroll	No hospital department is operated. A building called the infirmary is located on the grounds but has not been in use for a number of years, plumbing being out-of-order at present. A county physician is employed under contract.
Champaign	There is a hospital department in the same building. Other patients than County Home patients are received.
Cook	Only in emergencies.
DeWitt	A hospital department is operated in connection with the home and patients other than County Home inmates are received.
Du Page	No hospital department — Medical facilities for patients only.
*Grundy	March 1, 1944. Building and equipment leased to an individual, is now privately operated and with no agreement as to providing for indigent persons. It is now known as the Dena Erickson Convalescent Hospital, Wauponsee Township, Grundy County, R. F. D., Morris. The maximum capacity of the Erickson Hospital is approximately 50 persons. Forty-two persons were residents as of November 25, 1944 and 24 are OAP recipients and 6 are township cases (3 aliens and 3 not 65) and 12 not dependent on public assistance.
Henderson	No hospital department. If patients need nursing care a registered nurse may be hired.
Kane	No hospital department. There is an infirmary where practical nursing care is given to bed patients, but this cannot be considered hospital care as when cases get beyond the abilities of the persons in charge to care for them they are taken to a hospital in nearby communities.
Knox	As of November 25, seven patients paying own way.
Lake	No hospital department. If a County Home inmate is in need of hospital care, he is taken to the Lake County General Hospital in Waukegan, Illinois.
LaSalle	A hospital department is operated. Patients other than County Home inmates are not received.
Livingston	A hospital department is operated in connection with the County Home. Patients other than County Home inmates are not received.
McHenry	A hospital department is operated. This hospital receives other than County Home inmates on referral of the Overseer of the Poor. There are 19 patients in the hospital, 18 County Home inmates, 1 OAP.
McLean	The County Farm has a building and equipment and operated a hospital until about a year and a half ago. It was closed at that time because of inability to secure a qualified registered nurse. When the hospital was in oper-

*Is no longer a County Home.

	ation they did not receive patients other than County Farm inmates.
Macon	An infirmary is operated in connection with the County Home. A practical nurse is in charge and medical care is available although there is no resident physician. No patients other than County Home inmates are received.
Madison	A hospital department is operated in which only County Home inmates are received.
Morgan	No hospital department is operated with the County Home. There is a Women's attendant and a Men's attendant. In the past OAP recipients entered the County Home when they were helpless for care.
Peoria	The hospital department is operated in connection with the County Home and patients other than County Home patients can also be hospitalized in the institution.
Rock Island	No hospital department; however, limited medical services are available from a non-resident M.D. hired by the County Board on a yearly salary of $1452.
St. Clair	A hospital department is operated in connection with the County Home and patients other than County Home inmates are received.
Saline	There is no hospital department; however, the lessee is paid $1.00 per day for nursing service for one of the inmates who is 83 years old and bedfast.
Stephenson	No hospital department. County physician employed under contract.
Vermilion	In addition to the regular inmates, care is given to bed patients. The regular inmates rate is $20.00 monthly and the bed patients rate is $1.00 per day. This latter includes convalescent care for patients released from the regular hospitals.
Warren	A part of the building is set aside for cases which need additional medical care. The maximum capacity is 14. There is also a T. B. Ward which can handle three or four patients. Only County Home inmates are received.
Winnebago	There is a hospital department. Paid patients are received in contagious ward only.

JOURNAL'S CORRESPONDENT PICTURES HEALTH CONDITIONS IN FRANCE

A picture of health conditions in France during and after the European war is described by the Paris correspondent of *The Journal of the American Medical Association,* who said that "the infant mortality after the winter of 1944 was highest for this century."

In the August 25 issue of *The Journal*, the correspondent said:

"The number of deaths in 1939 exceeded the births by 29,000; the mortality rate was 15.5. Exclusive of the soldiers who died at the front, the prisoners and the deportees, it reached more than 18.0 in the course of the occupation and decreased to 17.0 in 1943. The infant mortality after the winter of 1944 was highest for this century. The morbidity followed the same trend. New cases of syphilis increased fivefold, typhoid fourfold and diphtheria threefold. Tuberculosis, amounting to 224 deaths per hundred thousand in 1930 and 172 in 1939, attained in 1942 the record figure of 234. There is a deplorable shortage of physicians, a catastrophic deficiency of nurses and social workers and lack of medicines. The number of hospitals is inadequate and their equipment is poor.

"The minister of health has announced projected reforms, but the needs are of such magnitude that best intentions run the risk of only partial fulfilment. . . .

"Medical education is to be improved; the preparation of the physician will be more methodical and better balanced. A more rigid control will replace the liberty formerly enjoyed by the students. A better distribution of physicians over the entire territory is likewise contemplated. At the same time the training of medical aids, particularly of nurses, will be improved, and their social status bettered. Control of physicians created on a new basis, and regulated by of dentists and of pharmacists will be the task of the professions themselves. . . .

"A check will be established against 'fake' pharmaceutic specialties and the 'black market' in medicines."

State Department of Public Health

THE ILLINOIS PLAN FOR CARE OF PREMATURE INFANTS

For several decades health departments have been moved toward the assumption of interest and responsibility in providing practical applications of the expanding knowledge of pediatric care. From the laboratory to the table of the examining physician we may observe a slow but steady progress of discoveries accruing to our continually decreasing infant mortality rates. We may, if we wish to look no further, regard with pride our 1944 provisional infant mortality rate of 33.2% per 1,000 live births, the fourth lowest in the country. This is less than half of what the figure was in 1925. But, we know that we can reduce this figure still further.

Studies of cause of infant mortality in Illinois, other states and the nation, point now to prematurity as the largest single remaining cause of death during the first year. Seven thousand infants, more or less, are born prematurely each year in our State and of the number, more than 40% fail to survive. This group of deaths accounts for one third or more of all deaths in the first year of life.

Some of these infants fall into the group still beyond the reaches of medical science; many, however, can be saved. Experience gained by the study of numerous investigators during the past twenty-five years has built up a body of scientific information capable of reducing this unnecessary loss of life by half. The present emphasis is upon the development of special hospital facilities for the care of premature infants and has produced favorable results in Chicago, Peoria, Milwaukee, and elsewhere. Approximately three years ago the Department of Public Health obtained approval and expressions of marked enthusiasm from the medical societies of Peoria and Sangamon counties for the establishment of a premature center in one large hospital in each county. At a recent meeting, the Council of the Illinois Medical Society voted their approval of the Illinois program for care of premature infants. The establishment of additional centers is a matter for local action.

Experience emphasizes one major fact — the premature infant is a physical entity of a highly specialized type and requires medical and nursing management of an equally specialized degree. The odd incubator tucked away here and there in the occasional hospital may produce brilliant results under favorable circumstances, but the incubator alone is only a fractional fulfillment of these extraordinary requirements. Painstaking care by qualified physicians and nurses experienced in the management of premature infants is indispensable.

The Illinois program for care of premature infants places approximately equal emphasis upon the necessity of qualified medical and nursing personnel and specifically designed hospital facilities. Qualified medical and nursing personnel means physicians and nurses prepared in their respective fields by post-graduate training in pediatrics and the care of the premature infant; specifically designed hospital facilities include a premature center or nursery, equipped with isolation facilities, incubator and oxygen beds, oxygen, plasma, blood, and other medical supplies essential for such care, and an accessory emergency incubator ambulance transport system for outlying communities. Vitally important in the nursing care is the contribution of the public health nurse in the areas served by premature centers for work with the family in the home

both before and after the discharge of the premature infant from the center. This essential adjunct is designed to assure continuity of the medical supervision and to avoid regrettable complications which might nullify the benefits attained in the hospital center.

A study of our actual results in the State program is of extreme interest in evaluating this type of program. In 1942, out of over five thousand neonatal deaths (deaths during the first month of life) 35.5% were certified as due to prematurity. Yet, in the two years during which the two premature stations were functioning in Peoria and Sangamon counties, mortality among almost 500 consecutive cases in this vulnerable group (including premature infants of birth weights ranging down to one pound nine ounces) was held to 17.3% in 1943, and 24.1% in 1944. The majority of deaths contributing to the higher figure in the 1944 series occurred in infants admitted from outlying areas to the center several days to weeks after delivery in moribund state.

Summary Statistics on Illinois Program for Care of Premature Infants for the Calendar Years 1943 and 1944

Birth Place	Hospital with Center	466 Infants
	Other hospital	16
	Home	16
	Total	498
Fate	Graduated	356*
	Expired	76*
Cause of Prematurity	Ruptured Membranes	91
	Multiply Pregnancy	50
	Syphilis	7
	Other	86
	Undetermined	178
Total Mortality	1943	17.3%
	1944	24.1%
State Cases**	Total number	92 Infants
	Average Cost	$129.50
	Average Discharge Weight	6 lbs.

*Totals show a discrepancy because of infants who were remaining in the centers at the end of calendar year.

**Cost of care assumed by the Illinois Department of Public Health.

Fiscal aspects of the Illinois program include stipends available to graduate nurses for special training, retainers for physicians serving as pediatric consultants to the centers, and payment for hospitalization of infants whose parents in the judgement of the attending physician are unable to afford such care. The foregoing table shows that 92 out of 498 cases were furnished hospital care at cost to the State. The average cost per infant was less than $130.

In addition to stimulating the provision of the specialized facilities in the areas, the Division of Maternal and Child Hygiene has arrangements with ambulance companies in the environs of the premature stations to transport the infants from distant communities to the special nurseries. The ambulance companies on call go to the premature station to procure the portable incubator and a trained nurse prior to driving to the community where the premature infant has been born. One of the salient items to survival of these infant cases is that the infant be referred immediately upon birth or earlier if premature delivery is anticipated. The second important requirement for survival is that the infant be kept warm and under continuous oxygen until it is transfered to the portable incubator. Third, no attempt should be made to feed the infant pending referral.

Experience to date with long transports has been extremely gratifying. Tiny premature infants, some at seven months gestation, have been brought to Peoria from Mendota, Astoria, Havanna, Galesburg, Abingdon, Pekin, East Peoria, Brimfield and Joliet; from McLeansboro, Edinburg, Lawrenceville, Mattoon, Mt. Vernon, and Flora to Springfield.

There are many areas in our state too remote from the two existing centers, Peoria and Springfield, for practical operation of the program. The need is for additional specialized units for premature care located in extra-central areas of the state. If such supplementary care is made available and shows the same encouraging results we have experienced in the relatively small number of cases in these early phases of our efforts in behalf of the premature, we may anticipate a gratifying salvage of human life in the neonatal period.

Printed copies of "The Illinois Plan for Care of Premature Infants" are available from the Division of Maternal & Child Hygiene.

Correspondence

COURSE IN CLINICAL ALLERGY

The School of Medicine, University of Pittsburgh, offers an Orientation Course in Clinical Allergy, under the sponsorship of The American Academy of Allergy, for five days, October 1 to 5, 1945, inclusive, at the School on Bayard Street, Pittsburgh, Pennsylvania. Fee $40.00; for veterans, service men, and residents $10.00. Registration for evening round table conferences only by special arrangements.

Inquiries should be addressed to William S. McEllroy, M.D., Dean, School of Medicine, University of Pittsburgh, Pittsburgh 13, Pennsylvania.

IMPORTANT ANNOUNCEMENT

Due to transportation difficulties the examination of the American Board of Ophthalmology, originally scheduled for Chicago, October, 1945. has been postponed to January 18th to 22nd inclusive, 1946.

ANNOUNCEMENT OF SPECIAL COURSE IN BRONCHO-ESOPHAGOLOGY

October 15 - 27, 1945

It will be noted that this special course will follow the Refresher Course in Otolaryngology, enabling those who can spare the time to pursue both courses in sequence on the same visit to Chicago.

The course in broncho-esophagology will be limited to twelve physicians and registration will be closed when this number has been registered. Applications for registration will be accepted in the order received.

The course will consist of didactic lectures, animal and cadaver demonstrations, practice in bronchoscopy, and esophagoscopy, diagnostic and surgical clinics, etc.

The tuition for the course is $50; laboratory fee is $50, making the total charge $100, which should be remitted with application.

This course will be given under the personal direction of Dr. Paul Holinger.

For further information and schedule address: Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Ill.

DEPARTMENT OF PUBLIC HEALTH

July 20, 1945

TO: Physicians and Hospital Superintendents

FROM: Division of Maternal and Child Hygiene

PROGRAM FOR THE CARE OF PREMATURE INFANTS

In down-state Illinois we have two Premature-Centers equipped to give essential specialized medical and nursing care to the prematurely born infant. These centers are located in St. Francis Hospital, Peoria, and St. John's Hospital in Springfield. Any infant whose weight at birth it 5 lbs. 8oz. or less may be admitted on a private basis or, if the attending physician finds the family is unable to assume the cost of hospital care payment may be made by the Illinois Department of Public Health.

PROCEDURE FOR REFERRAL OF CASES TO PREMATURE-CENTERS

1. Request admission by phoning immediately to the nearer Premature-Center.

PRIVATE CASES: The family should send an auto to the Premature-Center for a graduate nurse and a portable incubator, which are neces-

sary to transport the infant from place of birth to the Premature-Center.

STATE CASES: The Premature-Center will arrange for transportation of the infant via incubator ambulance from place of birth to the Premature-Center.

2. Every premature infant should be kept warm and under continuous oxygen from the moment of delivery until it is transferred to the portable incubator ambulance.
3. The attending physician may care for his patient himself if he is on the staff of the hospital in which the Premature-Center is located, or he may refer the infant to a physician or pediatrician associated with the Premature-Center. If State cases are referred, they are automatically transferred to the care of the pediatric consultant of the Premature-Center.
4. All complicated cases must be referred for consultation to a pediatrician or to the pediatric consultant of the Premature-Center.
5. Reports of the progress of the infant will be sent weekly to the private physicians of infants referred from distant communities.
6. The family (and physicians at a distance) will be informed when the baby is considered ready for discharge. The family should come to the Premature-Center prepared to take the infant home.

OMAHA MID-WEST CLINICAL SOCIETY TO MEET

The Omaha Mid-West Clinical Society will hold its thirteenth annual assembly in Omaha, October 22nd to 26th inclusive. Headquarters will be at the Hotel Paxton. A full five day program will be presented which will include addresses, clinics and round table discussions by distinguished guests, and symposia and lectures by members of the Society. There will be a daily motion picture program and scientific and technical exhibits.

Among the guests will be men prominent in many fields of medicine: Elmer Belt of Los Angeles (urologist); Sylvester N. Berens, Seattle (neurosurgeon); Guy A. Caldwell, New Orleans (orthopaedic surgeon); Archibald D. Campbell, Montreal (gynecologist and obstetrician); Burrill B. Crohn, New York (internist); Charles A. Doan, Columbus (internist, research); Lester R. Dragstedt, Chicago (surgeon); Robert H. Felix, Washington, D. C., (psychiatrist); Mr. J. Ketchum, Detroit (Executive Secretary of Michigan Medical Service); Edward J. McCormick, Toledo (Chairman, Council on Medical Service and Public Relations of the American Medical Association); Alan R. Moritz, Boston (pathologist — legal medicine); John A. Toomey, Cleveland (pediatrician) and Henry P. Wagener, Rochester (ophthalmologist).

Titles of the symposia to be presented on Tuesday and Thursday are as follows: The Arthritides; Bleeding from the Alimentary Tract; Fractures; Head Injuries; Penicillin; Technic for Lessening the Morbidity and Mortality in Obstretics. Friday, October 26th, will be given over to a panel on Military Medicine presented by personnel of the United States Army Medical Corps.

FLUORESCENT LIGHT IS NOT HARMFUL

Does fluorescent light possess harmful qualities not found in other forms of artificial illumnination? The Council on Industrial Health of the American Medical Association says "No."

Following an investigation by a joint committee on Industrial Ophthalmology, the Council, through its secretary, C. M. Peterson, M.D., reports in the A.M.A. *Journal* of August 25:

"Fluorescent lighting is not harmful to vision. It should not cause eyestrain if properly installed and used."

It was found that the light from fluorescent lamps resembles daylight more closely than that from tungsten-filament lamps. "This color resemblance to daylight," the Council reports, "is a desirable quality," adding:

"Infra-red energy found in fluorescent lighting as now manufactured produces no known physiologic effect except that due to heating. Fluorescent light generates less heat per candlepower than tungsten lamps.

"Glare occurs in any system of lighting. . . . Excessive light may produce symptoms of eyestrain in susceptible individuals regardless of source. Constitutional factors should be corrected as well as the amount and kind of light."

1945 Annual Reports

THE ANNUAL REPORTS: An Editorial Note.

All officers, members of the Council and chairmen of official committees of the Illinois State Medical Society were asked to submit annual reports for the House of Delegates at the usual time this year when it seemed possible that a meeting of the House of Delegates might be held during midsummer. When the application for such a meeting was not approved by the Committee on Conventions, the reports had been received and were being printed in the handbook which is always mailed in advance to properly elected delegates from all component societies so that they would be fully informed of the transactions of the Society during the past year before going to the annual meeting.

When permission to hold a meeting of the House of Delegates was denied the Council authorized the publication in the Illinois Medical Journal of the annual reports even though no official action has been taken upon any of them prior to their publication.

It is hoped that all delegates as well as members as a whole of this Society will read these annual reports so that they may know what the Society has been doing since the last annual meeting. Some new reports will be found this year which were not in the 1944 hand book, and many of these will be of general interest to all members.

It seems quite probable that at the 1946 annual meeting the House of Delegates will have annual reports for two consecutive years to act upon and this for the first time in the history of the Illinois State Medical Society.

REPORT OF THE PRESIDENT

To The Members of The House of Delegates:

The past year has been a momentous one in many respects. We have seen the end of the war in Europe. We are looking forward to an earlier termination of the war in the Pacific than we thought possible a year ago. We are beginning to make ready for the changes that will accompany the period of reconversion to a peace-time economy.

As citizens, we are interested in the well-being of our returning soldiers. As doctors, we are interested, vitally so, in maintaining the method of medical practice which has proved itself so efficient in the trials of war-time medicine and surgery, and equally so in the care of the civilian population.

The Illinois Medical Society has a vital interest in the war and its ensuing problems for many reasons, not the least of which is that approximately 4,500 doctors from this State are in the Armed Services. This leaves an unusually heavy burden upon those older men who are carrying on so well in this emergency. One of the obligations of those who have been at home during the war, is to make every effort to see to it that the returning doctors return to the type of practice they left to enter the Armed Services of their country. This obligation we cannot escape.

During the past year, I have had the pleasure of visiting a considerable number of County Societies over the State, and I have enjoyed the contacts with the various members whom I have met. In addition, there has been a surprising number of demands made by various organizations over the State. These organizations have some trend or desire to do something along health lines. They are well-intentioned, and are quite numerous. At the present time they are seeking advice and leadership, and one of our worthwhile functions is to see to it that they obtain this advice and this leadership. If we do not lead them, they will start out on projects with good intentions, but they may succumb to wrong leadership, and ultimately do more harm than good. They are numerous and influential, and it is to our interest to give them the leadership and advice for which they are asking at the present time. This is an obligation that every county medical society should face, and which it cannot properly avoid.

We are approximating a membership of 9,000, the largest in our history, and with returning men from the services taking a more active part in our organization, its continued progress seems assured.

There are some disturbing factors to be considered. A trend is apparent among certain bureaucratic groups in the country to blame almost everything on medical organizations, especially the American Medical Associ-

ation. To state that we, as doctors, are responsible for the number of men rejected in the draft, and to repeat the time-honored falsehood that medical care is unobtainable to the large group of middle-class people, because of its expense, the efforts of a foreign-born nurse to keep her disproved theory of disease before the public, are used to discredit us unjustly, and with this type of preliminary propaganda, modifications of the Wagner Bill have been introduced in several State Legislatures over the country. These bills, if passed, will completely revolutionize the practice of medicine, and totally destroy the "doctor-patient" relationship, as we now know it.

During the past year, the Officers and Committees of your Society have worked long and tirelessly to safeguard the interests of organized medicine, and those of the public as well. In reviewing their activities, I believe I can feel a justifiable pride in what they have accomplished, and in what they feel justified in recommending to you.

THE COUNCIL. The Council is composed of a group of scientific and sincere men. They meet regularly under the leadership of their Chairman, Dr. Percy Hopkins. This group has considered the problems with which we are faced, and has worked largely through its Committees, many of which have members who are not on the Council, so as to obtain the advice and experience of as many of the membership as possible.

THE SECRETARY. The business of a society with about 8,500 or 9,000 members, has to be administered daily and cannot wait for annual meetings of the House of Delegates, nor for the monthly meetings of the Council. Dr. Harold Camp, who has a national reputation of being the most efficient state secretary in the country, has carried on with unusual energy and ability. It is hard to imagine a state meeting being managed, as ours have been for many years, without his knowledge experience and energy to make it go. He is our representative and safeguard throughout the entire year, and to no little degree, our standing and our present position among state societies will be found due to the good judgment of Dr. Camp, his tact and his ability.

THE MATERNAL WELFARE COMMITTEE: Under the leadership of Dr. T. B. Williamson, this Committee has continued its good work. Maternal mortality and morbidity have reached a new low, despite the fact that under war-time conditions, countless numbers of service men's wives are being confined, many of them in strange communities, and all too often, enroute from one camp to another. Due to the excellent care furnished throughout the State, the maternal death rate has reached a new low. This is further proof that the health of the people in the State is in safe and skilled hands.

THE DEPARTMENT OF PUBLIC HEALTH: For many years the relationship between the Department of Public Health and the Illinois State Medical Society has been most cordial. Under the directorship of Dr. Roland Cross, this condition has been improved still further. County Health Units not only have had the advice of the State Department, but also have remained in close contact with, and have been largely controlled by the County Medical Societies. In communities where these units are in use, medical men in great majority, are in favor of continuing them. There has been constant co-operation between Dr. Cross, his associates in the Department, and the Council, and this attitude is going a long way to establish proper precedent for the future.

ANNUAL MEETING: Our annual meeting has been postponed, and may have to be cancelled because of war-time restrictions on conventions. However, by being postponed until August, it is thought that possibly improvement in the military status of the country might permit meetings of this type to be held. If it cannot be so held, a meeting of the House of Delegates will be in order, as it is essential that they meet at least once a year to transact important business of the Society.

THE BENEVOLENCE COMMITTEE: It is an unfortunate truth that a number of our older doctors who have passed the period of productive activity, have been unfortunate in financial affairs, or more likely, simply poor collectors, and are now objects of charity. Your Benevolence Committee is quietly and anonymously helping out all of these men, or their widows, when their wants are made known. This Committee is receiving financial support from the Society and from the Woman's Auxiliary, it being their major project at this time. It must continue to receive all the support it needs from the Society as it is doing commendable work.

THE JOURNAL: As the Editor will report, you will notice that the business management of the Journal has continued to improve, as has its editorial and scientific section. The Advisory Board passes on all advertising, and a group of outstanding men representing each of the specialties, pass on the scientific papers that are presented, and selects from these, the ones best suited for publication in the Journal. In the opinion of many competent men, our Journal is easily the most outstanding of any publication by a state medical society, in both the editorials and the scientific papers presented.

EDUCATIONAL COMMITTEE: The Educational Committee has continued its activities in spite of war-time difficulties. It is well to note that in this Committee, we as a State Society, pioneered this type of work. It has been very successful in building up a great amount of good will for the profession among the general public in the State, and has been copied, in varied degrees, by every other progressive state society in the country. It is one of our most important activities, and Miss McArthur and her staff, function throughout the year, with a high degree of efficiency. It is necessary to visit this department to fully realize the extent and importance of its work. It is our first line of defense against outside attacks.

ADVISORY COMMITTEE ON CARE OF PUBLIC ASSISTANCE RECIPIENTS: This group

too, has met regularly throughout the past year. In some respects, its work has been very successful; in other ways it has failed in some of its objectives. It does represent a liaison between organized medicine and a federal department. It has been able to show that a certain group of low-income citizens who are kept from being called "paupers" only by the phraseology of the law, can be furnished first-class medical care on the basis of free choice of physician, and that this care can be done with a minimum of federal interference. It is of great interest to see that in those counties where a medical advisory committee has met regularly and has worked efficiently, its members have taken over the leadership and in many cases have learned the importance of assuming that leadership in all phases of public health in their own communities, a condition recommended by the late Dr. M. L. Harris many years ago. This Committee has been able to continue to effect a reduction in the red-tape of administration which was so annoying at the start. It has been able to effect some improvement in the free schedules. It has obtained direct payment for the final illness, and there is a strong probability of its being able to arrange an improvement in surgical fees. It has also attempted to correct some local abuses of the act. In Cook County it has been unable to obtain an adjustment of some hospital abuses, and has therefore, broken off relations with the department in Chicago, while retaining satisfactory relations down state. It is to be hoped that the Chicago difficulties can be ironed out, and that this committee will continue with its main objective which is to keep the policy of medical care under the control of the profession itself, rather than leave it entirely in the hands of social workers and supervisors which would be the case, were this Committee to be disbanded.

COMMITTEE ON PREPAYMENT OF MEDICAL CARE: Last year the House of Delegates instructed the Council to appoint this Committee. It was at first thought to investigate the Blue Cross Plan, but the motion was amended to investigate all types of prepayment plans, both hospital and medical. During the past year, events have progressed so rapidly and so many changes are on the way, that this Committee's work has become of far more importance than its members ever suspected in the beginning, and their burden of responsibility has been greatly increased. During the past year, the Wagner-Murray-Dingell Bill aroused much concern among our members, and while it died in committee, it promises to be resurrected this year with much greater chances of being passed. In several State Legislatures, some of them our neighbors, similar bills have been introduced. They have a marked similarity in wording indicating that although they are introduced in different parts of the country, they have a common source, and perhaps a common author. These bills are definitely a menace to the practice of medicine and should be faced by a united profession. The work of the American Medical Association and of several of our neighboring states indicate that if we are to get off the defensive and are to prevent federal interference and control of the practice of medicine, that some substitute for state medicine needs to be offered. Due to the excellent work of state societies in the past, we have built up a background of good will. We have many supporters in the legislature and in Congress, but powerful forces are opposing us, and we need a united front against outside attacks. The indigent type of patient will always need support of the taxpayers for food, lodging and also medical care. This should be furnished at the township or county level, as is being done at the present time, and these people will continue to get good medical care as they now do. The chief argument of those who want to federalize the practice of medicine is that the low-income group, those who are self-supporting but with an income of below $2,500 per year, cannot afford the present costs of medical care. It is in the interests of this group in particular, that various states, and at least two counties in Illinois, have been investigating plans for insurance for the prepayment of medical care. The findings of this Committee will be recorded in their report, and it is to be hoped that they have been instrumental in aiding in the solution of this outstanding problem. They have met frequently and have worked hard. They have obtained ideas from a multiplicity of sources and have accumulated a remarkable amount of information. To many of us, including the writer, any insurance plan in the practice of medicine, is very objectionable. However, it appears that this is the only possible way to furnish medical service to this important group of the population and to avoid federal control, which we know, would be detrimental both to us and to the general public. A demand for prepayment medical insurance has been created over the entire country, and this demand is increasing so rapidly that action must be taken now or it will be another question of "too little and too late." I feel that the work of this Committee is the most important single accomplishment of the past year, and no matter what decision this House of Delegates reaches, the information obtained will be of inestimable value. The demand for this type of service has probably been created artificially through propaganda, but nevertheless, it has been created. The problem exists, and it will not solve itself. The medical profession must furnish leadership, or submit to domination by some undesirable federal plan.

MEETING: A recent meeting was called by the Michigan State Medical Society, and was attended by representatives of seventeen states and the District of Columbia, all these representing 62% of the nation's population. Plans were laid for inter-state cooperation with radio and legislative programs, as well as the further extension of prepayment medical care. These plans are all nebulous to date, but are practical and may lead to further strengthening of the practice of medicine in the country.

POST-WAR PLANS: With the end of the war in Europe, a certain amount of demobilization is probable. It is hoped that a reasonable number of medical officers will be released also, and they will be

able to relieve the shortage of doctors throughout the State. While it is true that the remaining doctors are doing an excellent job, and the health of the state has not suffered, these men left at home are carrying on under a terrific physical strain, and their ranks are being depleted steadily by the coronary and apoplexy routes. The return of even a small number of medical men would be a great help in relieving this pressure.

The Pacific War is estimated in some quarters, as requiring another two years for a successful conclusion. Following this, another problem will present itself, that is, the rehabilitation of the returning doctors. Plans are already under way by the American Medical Association to furnish post-graduate courses for those desiring them. A few state societies also have formulated their own plans for this purpose, and some have had an assessment to furnish financial aid in relocating those who need it. Some further constructive planning is needed.

In conclusion, it is felt that even though the Society has had to go through the stress of war-time conditions, under many handicaps, it has continued to grow and prosper. It is felt that the interest of its members in scientific medicine has continued to increase, and that the practice of medicine in the State is in good hands.

We hope shortly to see a post-war era, where the increasing advantage of a mechanized way of living will be reflected in easier practice for the doctors of the State, and facilities whereby they can render still better care for their patients.

Respectfully submitted,

E. P. COLEMAN, M.D.,
President.

REPORT OF THE PRESIDENT-ELECT

To The Members of The House of Delegates:

The duties and functions of a President-Elect are threefold—to attend as regularly as possible meetings of the Executive Committee, meetings of the Council, and to assist the President of the State Society, lighten his load and execute whatever assignments he may see fit to transfer. It has been both a pleasure and privilege to serve in that capacity under the leadership of Doctor Everett P. Coleman. It has been my good fortune to be able to attend all meetings of both the Executive Committee and the Council throughout the past year. The Executive Committee, it seems to me, serves a useful purpose in preparing and arranging the agenda for the Council and in arriving at concrete recommendations for Council consideration. These sessions are sometimes lengthy and arduous, but their objective is sound and they definitely make for efficiency. As the House of Delegates knows, the Council has in the past year had matters of unusual importance for consideration and disposition. Here again it has been a pleasure, privilege, and I might add, a revelation, to sit in and participate in a group which functions smoothly and passes sound judgment on a wide variety of agenda of interest to the medical profession and to the millions of people who depend upon organized medicine for leadership and protection.

As President-Elect it has been my happy privilege to attend and address many and sundry meetings and groups—some professional, others lay, too many of both to incorporate in this report. One, however, I feel merits particular attention. Early in this fiscal year, the Wisconsin State Medical Society invited the officers of the contiguous states (Illinois, Minnesota, Michigan and Indiana) to participate as guests in all of their sessions of both their Council and House of Delegates at their annual meeting, under the presidency of Doctor Curtin. It was interesting to note that their problems are almost identical with ours and that both their Council and their House of Delegates function in much similar a manner. I feel this type of invitation to the officers of neighboring states is not only a grand courtesy, but that the basic ideas is sound and is full of potential advantages to all concerned. Accordingly, I should like to recommend to this House of Delegates, that Illinois adopt a similar procedure and invite as guests to our meetings of the Council and our House of Delegates at our annual meeting, the officers, especially the President, President-Elect, and Secretary of the States of Wisconsin, Minnesota, Missouri, Indiana and Michigan.

Respectfully submitted,

ROBERT S. BERGHOFF, M.D.,
President-Elect.

REPORT OF THE SECRETARY AND TREASURER

To The Members of The House of Delegates:

In submitting this fourth annual report of your secretary since the outbreak of the war, we are pleased to inform you that the affairs of this society are in good shape. With the decreased number of physicians carrying on at home, the spirit of cooperation on the part of component county societies with the secretary's office has been highly commendable. We will necessarily divide this report into several sections. It seems desirable to report in some detail on the work of the Procurement and Assignment Service for Physicians, and on other present day problems as well as on those to be expected in the early post war period.

THE SOCIETY

In accordance with instructions received from the House of Delegates a year ago, we have continued to remit the dues of those members who are in service. The number has been increasing gradually each month since the beginning of the war. Membership data as well as complete information concerning the financial status as compared with one year ago, are attached to this report. It has been most interesting during the past year to receive dozens of letters from younger physicians now with our armed forces, who have never been in private practice, yet desire to obtain membership in our State Medical Society.

Several new committees have been named during the past year. Once more the number of committees mak-

ing annual reports is increasing. Among these committees is the one which was selected by the Chairman of the Council as requested last year by the House of Delegates and instructed to study all types of plans for prepayment hospitalization, medical and surgical care, and to submit a report at the 1945 annual meeting.

This committee, under the chairmanship of Dr. Charles H. Phifer, has had many meetings and will have a most interesting report for the consideration of this House of Delegates. The primary report is published in this Handbook, and the chairman will have an interesting supplementary report to present at the first meeting of the House.

The committee has devoted much time to consideration of the many plans now in operation as well as those to be operating in the near future in several states. There seems to be a popular demand for some plan whereby people in limited income groups may become insured against the hazards of illness, and especially those conditions frequently referred to as "catastrophic" illnesses.

We would respectfully urge every member of the House of Delegates to read carefully all reports published in the Handbook, and to note especially the vast amount of work which has been done during the past year by the Council and the several highly important committees. Each Councilor has reported on conditions in his own Councilor District, and the Chairman of the Council has reviewed briefly the work which the Council as a whole has done during the past fiscal year.

PROCUREMENT AND ASSIGNMENT SERVICE

Last September we were informed through the office of the Surgeon General of the U. S. Army that they no longer required the assistance of Procurement and Assignment Service in procuring necessary personnel for the Army Medical Corps, as the supply of interns and residents would care for their needs. The Navy, however, still needed several thousand more physicians and we have endeavored in every way possible to aid them in getting the desired quota from Illinois. Standards of the Navy have been lowered and many of the younger physicians previously rejected, were being called in for re-examination. Many were found acceptable.

With approximately 4,500 Illinois physicians with the armed forces and in other essential war time government positions, and with most communities in the state depending on older men for civilian medical services, many urgent calls have been received from various parts of the state where these older men were disabled or had died, leaving an unquestionable need for additional medical personnel. We have endeavored in every way possible to aid in getting physicians to relocate. Although relocation is entirely on a voluntary basis we were fortunate in getting quite a number of physicians to go into localities where there were not enough doctors left to give adequate civilian care.

When we received information that physicians from Illinois were given medical discharges from active duty, we wrote to each of them to see if they desired information relative to desirable locations, and we offered to assist them in every way possible. Individual physicians and clinical groups in a number of Illinois localities were anxious to procure additional personnel in their respective organizations. A number of men were found who were interested in this type of work.

COOPERATION WITH SELECTIVE SERVICE

National headquarters of the Selective Service System in an amendment to Local Board Memorandum No. 115, revised the procedures relative to the deferment of men under the age of 38, and designated Procurement and Assignment Service for Physicians as one of the fifteen certifying agencies. In the past we have made our recommendations concerning the Selective Service classification of physicians to the State Director through the State Medical Officer, and he conveyed our recommendations to the local boards. Under the new procedure we make our recommendations direct to the local boards and furnish the State Director with copies of our letters.

The Procurement and Assignment Service for Physicians in Illinois has had a most harmonious relationship with the State Medical Officer and the Assistant State Medical Officer, both of whom are members in good standing of the Illinois State Medical Society, and who have carried on their official duties in a highly satisfactory manner. It is interesting to note that both of these medical officers, Major Robert H. Sykes and Captain E. H. Blair, complied with the requests of the Procurement and Assignment Service soon after our country entered the war, and applied for commissions and were accepted. Likewise we have had excellent cooperation with the State Director of Selective Service in Illinois, Colonel Paul G. Armstrong. The Procurement and Assignment Service for Physicians in Illinois wishes to take this opportunity to thank these gentlemen for their splendid work and cooperation.

THE BUREAU OF INFORMATION OF THE AMERICAN MEDICAL ASSOCIATION

The Bureau of Information has been set up within the A.M.A. to provide means for helping returned medical officers with their many problems in connection with their return to civilian practice, or in the case of the younger men who have not been in practice previously, to aid them in the selection of a desirable location. The Bureau has endeavored to get information concerning the needs of communities for physicians. They have enlisted the aid of the state and county medical society secretaries to procure much of the desired information. All data relative to a county is entered on a form which is called the "county summary sheet."

The summary sheet calls for information which it is believed will be most helpful to the discharged medical officer who writes to the Bureau for aid in the selection of a desirable location. The following information is given:

1. Officers of the state and county medical societies.
2. Approved hospitals within the county.

3. Public health facilities available.
4. Other medical facilities within the county.
5. Physicians within the several age groups showing the number in active practice, health department work, teaching positions, and those retired.
6. General statements relative to the county.
7. Location and climate.
8. Population of the county.
9. Principal cities.
10. Nearest large center.
11. Schools: public, private and parochial.
12. Retail sales.
13. Total retail sales.
14. Resident telephones within the county.
15. Miles of highway.
16. Dwelling units in the county.
17. Remarks.

Information is carefully worked out for each county so that accurate material which is desired will be available. Various organizations and groups have been consulted to get information other than that of a strictly medical nature. The pertinent data relative to medical information are supplied by the county medical society secretaries and by local Procurement and Assignment Service committees. We have been informed by the Director of the Bureau that the information received from Illinois is most complete in every detail and that it will be of tremendous value to the Bureau.

CARD FILES

The secretary's office recently completed the setting up of a duplicate set of card records for every physician registered within the state. Previously adequate records were available for all members of the Illinois State Medical Society but we were desirous of securing additional information relative to non-members as well. One set is filed alphabetically while the other is filed by counties. Information relative to the physical condition of the physicans is also included in these records which we believe will be of much value in the postwar period and in giving accurate information to returning medical officers who ask for assistance in selecting a desirable location.

Each county has been divided into two sections—active and inactive. In the active group we have filed cards for those in active practice, while in the inactive group we have those listed who are retired, those in service, and those who have moved to other locations. It has been practically impossible in the past to keep accurate records of all Illinois physicians as there have been so many moving from one location to another, or perhaps from Illinois to other states, etc., and we have never been notified promptly of the arrival of new physicians from other states or those who have recently completed internships or residencies and have entered private practice in this state. We hope in the future to maintain this accurate and complete record. We can do this only through the proper type of cooperation on the part of all county society secretaries.

POST WAR MEDICAL SERVICE

Post War Medical Service is one of the highly important considerations at this time. It seems quite appropriate indeed for the medical profession to assume leadership in developing and supervising these plans rather than to see them supervised by political units. There has been a growing demand on the part of certain groups throughout this country for medical care on a taxation basis. It has been stated that a large percentage of the American people are denied adequate care in time of sickness. Many investigations made show that this group constitutes a very small minority of our population.

A new Dingell Bill was introduced in Congress last January and the medical provisions are almost identical with those in the original Wagner-Murray-Dingell Bill. Bills have been introduced in a number of states which propose to set up a state wide medical care plan on a taxation basis with the employer and the employee sharing the costs. Several have urged that hospitals be built in all parts of the country where hospital services are not available, and they frequently tell of some 1,500 counties within the United States where there are no hospital beds available.

Recommendations have been made whereby clinical groups would be on duty all of the time in hospitals. In several states hospitals would be built within the counties, then a large base hospital within the state to be manned by specialists and to receive the complicated cases or those requiring highly technical operations. To tell of all plans and recommendations which have been made in recent months supposedly to improve the health of the nation would require all the space in this Handbook.

We should by all means have available within our own society complete information at all times as to the need for physicians in every part of the state. We should be able to give inquiring physicians, especially those who have been demobilized from the services and are seeking locations, much information concerning the local prospects so that they will know in advance whether or not they will be interested in the various locations. We now have reliable information for each county giving the many items of general interest as was presented under the heading "Bureau of Information of the American Medical Association," and at the time this report is written, we have answered quite a number of letters received from returning medical officers now ready to resume private practice.

Many of the returning physicians will desire to take post graduate work or short refresher courses. It seems desirable that we endeavor to confer with Deans of our Class A schools and see what type of programs may be arranged in the near future so that following "V-J" Day we will have the information available.

We must remember that more than 20,000 physicians now with the armed forces have never been in private practice. We must have plans to aid these men who decide to enter practice in the State of Illinois. This Society has designated an existing committee to act as the Committee on Post War Medical Service Plans. The Committee has given much consideration to these problems and aids the returning medical officer in every way possible. Information from every county

is being procured and filed in the secretary's office and the files are almost complete at this time.

DEATH OF PROMINENT MEMBERS

There were 172 deaths of members reported to the secretary's office during the past fiscal year. It is most unfortunate that we frequently receive a notice from the widow of a deceased member telling of his death perhaps a year or more previously, yet no official notice was received from the component society. We once more ask each county society secretary to notify the state society secretary's office as soon as possible regarding any change in the medical personnel in the county so that our records and those of the A.M.A., our Journal mailing lists, etc., can be kept in order and embarrassing situations such as is mentioned above would become unnecessary.

Frederic A. Besley, Waukegan, died on August 16, 1944. Doctor Besley was an outstanding surgeon, a founder of the American College of Surgeons, its treasurer for eleven years, and in 1937-1938, president of the College. He became a clinical instructor in surgery at Northwestern University Medical School in 1899, was made professor of surgery at that school in 1915. He was chief surgeon for the Northwestern University Base Hospital, Unit No. 12, retiring at the end of World War I with the rank of Colonel. Doctor Besley was always interested in his medical and surgical affiliations and appeared many times on programs at the annual meetings of this society.

Irving S. Cutter, formerly Dean of Northwestern University Medical School and Health Editor of the Chicago Tribune, died on February 2, 1945. For several years Doctor Cutter acted as Historian for the Illinois State Medical Society and submitted highly interesting annual reports to our House of Delegates. He graduated from the University of Nebraska Medical School in 1910, then became an instructor, and later Professor of Biochemistry and Director of the Laboratory, then from 1915 to 1925, Dean of the Medical School. In 1925 he became Dean of Northwestern University Medical School acting in that capacity until 1941 when he retired to become Professor Emeritus of Medicine and Dean. Always a prolific writer, Doctor Cutter was an outstanding teacher and medical historian, producing many articles, brochures and books during his teaching career.

Joseph Brenneman, Professor of Pediatrics at Northwestern University Medical School from 1921 to 1941, and an outstanding pediatrician of this country, died at his home in Reading, Vermont on July 2, 1944. Dr. Brenneman, for many years, was a regular attendant at the annual meetings of this society, appeared on many annual meeting programs and talked at district and county society meetings throughout the state.

Arthur J. Fletcher of Danville died July 31, 1944. Another prominent pediatrician for many years, Doctor Fletcher was very active in the affairs of his county and state medical societies, having been chairman of the Section on Pediatrics recently.

Frederick B. Moorehead, Chicago, died at the Presbyterian Hospital in that city after a long illness, on August 29, 1944. Doctor Moorehead was Professor of Oral and Plastic Surgery at the University of Illinois College of Medicine, the University of Illinois College of Dentistry, attending oral and plastic surgeon at Presbyterian and other Chicago hospitals.

Charles W. Hall, Mt. Vernon, died June 21, 1944. Doctor Hall was on the surgical staff at Camp Grant for more than a year during the first world war, then went overseas, received his majority and was placed in command of a large evacuation hospital. For years he was associated with his uncle, Doctor Andy Hall of Mt. Vernon, and was very active in the affairs of his own component society as well as the state society.

F. N. Wells, Pittsfield, for many years secretary of the Pike County Medical Society, died June 27, 1944. Joseph L. Sherrick, Monmouth, a regular attendant at the annual meetings, formerly secretary and chairman of the Section on Medicine, died July 28, 1944.

Lt. Col. Melbourne W. Boynton, Chicago, was graduated from the parachute school at Ft. Benning, Georgia, and since that time was assigned to the office of flying safety. In that capacity he made experimental jumps to test landing procedures, and was attempting to develop safety procedures for air crews when forced to bail out at high altitudes. While making a scientific test on August 19, 1944 he plunged eight miles to his death when his parachute failed to open.

Charles O. Burgess, Monmouth, for many years a member of this House of Delegates, died at his home on August 24, 1944, following a long and disabling illness. Wilbur Stuart Wood, Decatur, died following a heart attack while on a vacation in Wisconsin, on August 7, 1944. Doctor Wood's work in the care of crippled children was outstanding.

Jacob M. Mora, Chicago, assistant professor of surgery at the University of Illinois College of Medicine, staff member of a number of Chicago hospitals, and frequently appearing before medical societies in various parts of the state, died February 10, 1945. Adolph Hartung, Chicago, professor of radiology at the University of Illinois College of Medicine for more than thirty years, died on May 29, 1944.

Maurice L. Blatt, professor of pediatrics at the University of Illinois College of Medicine, head of the Children's Disease Department at Cook County Hospital, a prominent member of the staff of several hospitals, died December 10, 1944. Doctor Blatt was a regular attendant at the annual meetings of this society, was chairman of the Veterans' Service Committee, and active in other capacities at the time of his death. He served as a sergeant in the Spanish-American War, and as a medical inspector of the 33rd Division in the first world war. He was Lieutenant Colonel and Executive Officer of the Illinois National Guard for a number of years.

Many other faithful and prominent members of this society have passed on during the past year, but time and space do not permit elaborating on many of them individually. Among those who have died since the last annual meeting are L. J. May, Anna; J. A. Fisher, Metropolis; William D. Snively, Rock Island;

George M. Bussey, Chicago; Warren T. Heaps, Kewanee; Victor M. Brian, Lawrenceville; Ward E. Potter, Oak Park; Hugh L. Davison, Urbana; Elmer L. Kenyon, Chicago; Henry R. Boettcher, Chicago; Herman J. Neubauer, Hinckley and Bayard Holmes, Chicago.

This office has received official notification from secretaries regarding the death of 172 members during the past fiscal year. Once more may we respectfully request all secretaries to notify our office as soon as possible of the changes in the medical personnel in the county so that our records may be kept correctly.

The medical profession of Illinois has carried on during trying war conditions for another year. With the vast majority of physicians acceptable for service, now with our armed forces, many counties have only partially disabled and elderly physicians remaining on home duty. Casualties among our members are necessarily higher under these conditions, yet these men in civilian practice are determined to carry on as long as it is possible for them to do so.

MEMBERSHIP DATA

Members in good standing as of April 30, 1944		8,787
Added during the year:		
New members	523	
Reinstatements	53	
Total Added	576	
		9,363
Dropped during the year:		
Died	172	
Moved away	32	
Resigned	37	
Duplicates in file	14	
Dropped for nonpayment of dues	242	
Expelled	1	
Total Dropped	498	
Net Total, April 30, 1945		8,865

FRED N. SETTERDAHL
Certified Public Accountant
224 Robinson Building
Rock Island, Illinois
May 18, 1945

To The Members of The House of Delegates:
Illinois State Medical Society:

CERTIFICATE OF AUDIT

I have audited the following accounts of your Society for the fiscal year ended April 30, 1945:

Secretary's Office—Dr. H. M. Camp,
Journal Office—Mr. L. E. Malley,
Educational Committee—Miss Jean McArthur, Secy.,
Benevolence Fund—Dr. H. M. Camp.

SECRETARY'S ACCOUNTS:

Receipts: Dues received from Component Societies have been verified with duplicate receipts, the master ledger cards of each Component Society and compared with the Secretary's Report as published.

The Journal Receipts have been verified with reports from the Manager, etc. Other receipts consist of Exhibit rentals, Journal Subscriptions, Interest, etc.

Payments: Payments are made by check and are supported by approved vouchers, orders, invoices, etc.

All funds are deposited in the name of the Society and were reconciled with statements received from depository banks.

Bonds amounting to $95,000.00, par value, were examined. During the year bonds amounting to $10,000.00 were called and Government Bonds amounting to $35,000.00 were purchased. Chicago & Northwestern Railway Company Bonds, par value of $5,000.00, were converted into 31 and 70-100 shares of voting trust certificates for comomn stock. Bonds called are included in the cash receipts and the bonds purchased are included with the payments.

The accounts of the various departments have been well kept and in my opinion represent the true transactions for the year. The Council will be furnished with a detailed audit report.

Respectfully,
FRED N. SETTERDAHL,
Certified Public Accountant.

FINANCIAL REPORT OF THE SECRETARY

Receipts from County Societies

Adams	$ 320.00	Iroquois	8.00
Alexander	88.00	Jackson	152.00
Bond	8.00	Jasper	24.00
Boone		Jefferson-Hamilton	224.00
Bureau	240.00	Jersey	32.00
Carroll	120.00	Jo Daviess	88.00
Cass	96.00	Johnson	24.00
Champaign	1,064.00	Kane	840.00
Chicago Medical Society	29,792.00	Kankakee	312.00
Christian		Knox	248.00
Clark	74.00	Lake	586.00
Clay	72.00	LaSalle	544.00
Clinton	96.00	Lawrence	
Coles-Cumberland	288.00	Lee	160.00
Crawford	32.00	Livingston	168.00
DeKalb	168.00	Logan	144.00
DeWitt	8.00	McDonough	134.00
Douglas	232.00	McHenry	288.00
DuPage	568.00	McLean	424.00
Edgar	64.00	Macon	1,134.00
Edwards	16.00	Macoupin	184.00
Effingham	208.00	Madison	944.00
Fayette	48.00	Marion	168.00
Ford	148.00	Mason	16.00
Franklin	180.00	Massac	88.00
Fulton	176.00	Menard	72.00
Gallatin		Mercer	72.00
Greene	88.00	Monroe	48.00
Hancock	128.00	Montgomery	104.00
Hardin		Morgan	384.00
Henderson	16.00	Moultrie	34.00
Henry	248.00	Ogle	120.00
		Peoria	904.00

Perry	40.00	Tazewell	241.33
Piatt	52.00	Union	104.00
Pike	96.00	Vermilion	376.00
Pope		Wabash	80.00
Pulaski	40.00	Warren	146.00
Randolph	122.00	Washington	72.00
Richland	118.00	Wayne	56.00
Rock Island	704.00	White	120.00
St. Clair	802.00	Whiteside	136.00
Saline	192.00	Will-Grundy	660.00
Sangamon	786.00	Williamson	162.00
Schuyler	8.00	Winnebago	1,232.00
Shelby	104.00	Woodford	88.00
Stephenson			

Total $49,885.33

RECEIPTS AND PAYMENTS

May 1, 1944 to April 30, 1945

Receipts

Component Societies	$49,885.33	
Subscriptions—Journal	177.10	
Advertising—Journal	41,342.95	
Exhibits—State Meeting (1944 Meeting)	2,450.00	
Exhibits—State Meeting (1945 Meeting)	3,675.00	
Interest—Bonds	2,218.75	
Dividends (C. & N. W. Ry. Co.)	155.00	
Bonds Called	10,000.00	
Bonds Called—Premiums	250.00	
Bank Waiver—Dividend Sheridan Trust & Savings	320.07	
Miscellaneous and Refunds	97.79	
Total Receipts		$110,571.99
Cash Balance May 1, 1944		78,759.39
Total		$189,331.38

Payments

Secretary's Office Expense	$12,661.25	
Council Expense	4,524.35	
Educational and Scientific Service Committee Expense	10,384.89	
A.M.A. Meeting Expense	841.28	
State Meeting Expense	6,820.05	
Maternal Welfare Committee Expense	279.98	
Post Graduate Committee Expense	885.34	
Legal & General Counsel Expense	1,178.85	
Medical Service and Public Relations Committee	7,295.38	
Advisory Committee on Medical Care for Public Assistance Recipients Expence	371.84	
Procurement & Assignment Committee Expense	530.63	
Journal Expense	31,119.85	
Committee to Investigate Prepayment Plans for Medical and Surgical Care Expense	1,658.79	
Committee on Archives Expense	100.00	
Committee on Professional Demeanor Expense	16.70	
Unemployment Insurance Deposit	86.61	
Government Bonds Purchased	35,000.00	
Total Payments		$113,755.79
Cash Balance April 30, 1945		75,575.59
Total		$189,331.38

Respectfully submitted,

HAROLD M. CAMP, M.D.,
Secretary.

REPORT OF THE CHAIRMAN OF THE COUNCIL

To The Members of The House of Delegates:

The Council of the Illinois State Medical Society has met regularly since the last meeting of the House of Delegates in Chicago in May, 1944. These meetings have been well attended and the business of the Society which has come before the Council has been seriously considered before being disposed of.

Because of the ruling of the Office of Defense Transportation not to approve applications for conferences of groups other than meetings of church organizations, some union meetings and other conferences directly connected with the war effort, we have not applied for permission to hold our annual meeting in May. No meetings of medical societies have been approved up to the time of the writing of this report other than the meetings which were entirely local in character having to do with the war effort. It is doubtful at this time whether or not it will be possible to include the scientific programs in the general meeting of the Illinois State Medical Society or whether the meeting will be limited to a meeting of the House of Delegates. The Council recommended to arrange a meeting of the House of Delegates for August 14, 15, 16 so that the necessary business of the State Society may be conducted. Further information in this regard will be furnished by the secretary. The Scientific Work Committee and the General Chairman of the Committee on Arrangements have previously met and arranged a scientific program so that if it is possible to hold a general meeting the scientific program will have been provided for.

The Journal Committee has had several meetings with the Editor, the Editorial Board and the Business Manager of the Journal and the high quality of the scientific and original papers now published in the Journal is apparent. The physical make-up of the Journal even with the need to conserve paper has been a cause for considerable favorable comment and has caused no dearth of prospective advertisers. The Editorial Board as well as the Journal Committee passes upon the desirability of advertisements and many proffered ads are declined. Some advertisements of prod-

ucts have been cancelled for specific reasons during the past year and revenue certainly is not the primary object considered in the publication of the Journal.

The Council acts in an advisory capacity to the State Committee of Procurement and Assignment which was enlarged one year ago. It has not been necessary this past year to spend much time advising the State Committee but the medical profession may look with pride upon its efforts to impartially determine the availability of men for service as well as the satisfactory relocation of medical men throughout the state. The Society has been able to procure much valuable information regarding the medical men in the state and this will be placed in the files of the Illinois State Medical Society.

The Advisory Committee to the Illinois Public Aid Commission has made progress in obtaining further just payments for physicians throughout the State. The program in general throughout the state other than in Cook County has been one of general mutual satisfaction between the members of the Public Aid Commission and the Illinois State Medical Society. A subcommittee has also reached a satisfactory agreement with the State officials in connection with the treatment of trachoma and the blind throughout the State during the past year.

At the last meeting of the House of Delegates the matter of contract practice as reported by the Advisory Committee was reviewed by the Reference Committee with the following report:

1. The House disapproves in principle contract practice between governmental units and doctors.
2. That county societies in which contract practice exists between doctors and governmental units be advised of such contracts and be urged to have doctors cease such practice as being not best for either the public or the profession.
3. That the Council be informed of such practice and that the Council advise individual Councilors to activate the local society in cleaning up the problem.

This matter has been taken up with the individual Councilors at several Council meetings but thus far with little apparent effect.

Four post-graduate meetings have been held with no violation of the rulings of the Director of Transportation. The meetings have been well attended, valuable, and of very little expense to the Society. The number of these meetings should be increased as rapidly as possible for the men returning from service.

The Committee on Medical Service and Public Relations has been active throughout the year. For the first time in its history the Committee saw fit to answer inquiries regarding the records of candidates for Congress in so far as they pertained to medical practice. The Committee felt this was desirable because of the pending and proposed legislation at Washington with its effect upon the welfare of the people and the medical profession. The Executive Secretary of this Committee is a busy and efficient individual who has spent much time the past year debating and exploiting the undesirable features of certain legislation. The State Legislature is now in session and his advice and cooperation are frequently sought.

Doctor Roland R. Cross, the Director of the Department of Public Health of Illinois continues to be most cooperative with the Council and the Illinois State Medical Society. He attends all Council meetings as well as many committee meetings in addition and a mutual relationship of trust and respect exists between Dr. Cross and the State Society.

Dues of members in service in the Army and Navy have been remitted this past year and the Council recommends to the House of Delegates that this practice be continued this year. The financial condition of the Society is such that it should be possible to do this without any financial question. Some additional expense has been incurred in connection with the many meetings of the special committee appointed to study prepayment medical care plans but this study has been most far reaching and has been continued throughout the year. It is felt by the Council that this cost has been minimal and that the money has been well spent. The Committee to study prepayment medical care plans has been very busily engaged throughout the year in meeting with representatives of organizations engaged in the various fields of hospital and medical care, and insurance, as well as people having to do with that particular low income group for which this project is proposed. A sincere effort has been made to appoint a Committee, the personnel of which is truly representative of most of the legitimately different fields in the practice of medicine. This Committee is especially deserving of the commendation of the Society for the amount of time devoted to the study of its problems, having met at least weekly most weeks since last fall and under present conditions this fact is surely worthy of recognition. The report of this Committee should receive the serious and unbiased consideration of this House of Delegates.

The Council approved a change in the By-Laws of the Woman's Auxiliary whereby the widow of a physician may retain her auxiliary membership and retain all privileges except that of becoming President of the Auxiliary. The Auxiliary was also reminded that it would be necessary for them to apply to the Office of Defense Transportation for permission to hold their meeting this year.

The Chairman of the Council having served his second term desires to express appreciation and thanks for the honor conferred upon him. It has been a pleasure to be associated with the men in the Council and on the various committees that really work. He is grateful to the Council for its tolerance of his capacity to preside as moderator at its meetings. He is grateful also to the men on the committees who have been so faithful in giving up their own time to try to accomplish things for the State Society. He is grateful to Dr. Camp for his continued cooperation and helpfulness. He and his office have always been ready to provide any information or help that may be

requested. It has been a pleasure to work with them.

Respectfully submitted,

PERCY E. HOPKINS, M.D.,
Chairman of the Council.

REPORT OF THE COUNCILOR OF THE FIRST DISTRICT

To The Members of The House of Delegates:

In submitting my annual report for the year 1944-1945 I am obliged to say that things are going on about as usual. It has been a more quiet year, if anything, than last year. I believe it is due to the fact that the War Manpower Commission is not combing the rank and file quite so heavily as before and the men are more settled in their own minds as to what is taking place.

I have attended meetings of all the Societies except two in the west of the district and it seems hard to get action in those Societies. However, the others are functioning well. One Society that did not function well last year is again going strong and it serves to emphasize the fact that a Society is no better than its officers.

It was my privilege recently to present a 50-Year button to Dr. James S. Rankin of DeKalb. I have never been to a meeting where so much honor was bestowed on a man on such an occasion. This was a joint meeting of the DeKalb County Tuberculosis Society and the DeKalb County Medical Society and there were about 300 people present and several guests from outside the Society. From the honor shown Dr. Rankin, who has been active in the Tuberculosis Society over many years, it really seems a privilege to live long enough to merit a 50-Year button.

Considerable interest has been shown in some Societies in a pre-payment plan of its own which it is hoped will help solve some of the problems facing the practice of medicine. It is to be hoped that the State Society can soon present a practical plan that will be suitable for the entire state. It is to be hoped that more interest will be placed on the constructive side of this problem and less on the negative side as manifest in the Gary plan.

My wish for the coming year is for a more intelligent and constructive cooperation in the practice of medicine.

Respectfully submitted,

L. J. HUGHES, M.D.,
Councilor, First District

REPORT OF THE COUNCILOR OF THE SECOND DISTRICT

To The Members of The House of Delegates:

The county societies of the Second District have passed through another war year very satisfactorily. In spite of the heavy demands on the time of the doctors at home, meetings generally have been held as usual and good programs have been provided. With the multitude of "problems," so-called, confronting the profession it seems worthy of mention that a scientific program still attracts the best attendance and seems of the most interest.

Physicians are doing all they can to meet the needs of their communities, and there is little complaint that medical service is seriously inadequate. As a result, in part at least, of the crowded condition of the hospitals, the nursing care situation has been difficult but again, not seriously inadequate.

During the past year the Councilor of the Second District has had less opportunity than ever before to visit the societies in his district but the matters requiring his attention have been few and have been taken care of without difficulty.

Respectfully submitted,

EDGAR C. COOK, M.D.,
Councilor, Second District.

REPORTS OF THE COUNCILORS OF THE THIRD DISTRICT

To The Members of The House of Delegates:

The Third District reports in good condition in spite of the war and its inroads on our membership.

On January 1, 1945 the membership of Chicago Medical Society was 5,545 which included two associate members, 43 non-resident members and 105 intern members, an increase of 250 members over the preceding year.

To date 1,773 members are in military service and of this number 13 have died while on active duty.

The Central Society and its 15 branch organizations hold monthly meetings, the business being transacted by the Council which meets once a month.

The Chicago Medical Society continues to remit the dues of the men in service.

The Second Clinical Conference was scheduled to be held February 27th, 28th and March 1st and the program had been completed. It promised to be a successful meeting as the program included men from all over the country. The preliminary programs were printed and ready to be mailed to physicians in nine surrounding states, when the War Committee on Conventions ruled that the meeting would have to be cancelled. It is hoped that this Conference can be resumed next year.

In addition to the regular standing Committee activities several new Committees have been appointed by the Chairman of the Council—for instance:

Special Committee to Study the Tuberculosis Problem in Cook County.

Dr. Robert Berghoff was appointed Chairman of this Special Committee which was a fact-finding Committee to conduct a survey of the tuberculosis situation as it exists today in the County of Cook and the City of Chicago.

Through the cooperation of Dr. Roland Cross, Director of the State Department of Public Health the services of Major A. W. Newitt and his associate Major J. Hosier of the U. S. Public Health Service were secured.

The survey was completed and approved by the Council of the Chicago Medical Society. This is the first survey to ever be completed, although at least six times in the last 25 years such a survey has been ordered but none was ever completed.

The survey begins with the history of tuberculosis control in the County of Cook and the City of Chicago for the past twenty-five years and then brings the history up to date. It covers all the facilities for tuberculosis control both in hospitals and sanatoria and in clinics. It is replete with statistical data, charts and colored graphs. Finally it devotes more than twenty pages to suggestions and to concrete recommendations. This survey completes a state wide survey on tuberculosis and is therefore very timely.

Drs. Berghoff and Hutton, members of the Board of Advisors to the Department of Public Health for the State of Illinois took this report to Springfield to Dr. Cross and through the Department to the Governor of Illinois to aid him in his post-war planning for tuberculosis control throughout the State.

The Council voted that the Chairman appoint a Permanent Committee on Tuberculosis Control to carry on the work that this survey has made possible. (Dr. Muller has not yet appointed this permanent committee.)

Special Committee to Study Prepayment Plans.

Dr. Harold Miller was appointed Chairman of this Special Committee.

At the February meeting of the Council the Committee reported that they believed the first step in the consideration of Medical Service Plans is the introduction of an Enabling Act to the legislature of the State of Illinois. The Council granted permission to initiate the action necessary.

The Committee requested the attorneys for the American Medical Association who have had much experience in drawing up plans all over the country, to draw up an "Enabling Act" embodying certain suggestions of the Committee and including important factors that are of proven merit from other state plans, namely New York, New Jersey, Michigan, Philadelphia, etc. The Bureau of Legal Medicine and Legislation prepared such an Enabling Act and Mr. McDavitt, attorney, submitted this plan to the Council at its April meeting stating that it was not the finished bill.

The Council voted that the Committee be granted permission to proceed in its efforts to present an "Enabling Act" at the term of the legislature.

Committee on Medical Testimony.

For the past three years the Council has had under consideration the appointment of a Committee on Medical Testimony. The Committee was recently appointed by the Chairman of the Council.

Dr. Oscar Hawkinson was appointed Chairman. The Committee will be organized after the manner of the so-called Minnesota plan which has been functioning so well for the past three years. In questionable cases the Committee may ask any Court of Judicial procedure to provide it with the transcript of testimony to which its attention has been called. The Committee will have authority to investigate irregularities and recommend disciplinary measures against those who violate the ethical medical principles and to report any gross irregularities to the Department of Registration and Education.

Ration Committee.

This Committee has been in existence for the past two years and is of material aid to members in helping to adjust differences with the OPA.

Dr. Scatliff is Chairman of this Committee and was instrumental in helping to provide these various special diets. The Committee is being enlarged to seven members and in the future will endeavor not only to intercede for doctors who feel their requests are not being properly handled, but also to act in an advisory capacity to the OPA when it is confronted with what it regards as questionable requests from members of the profession.

The OPA has reported that from one-third to one-half of all requests signed by physicians for additional rationed foods are for anemia. Therefore it seemed advisable that a study of the special food needs in treatment of this disease be made and the Ration Committee recommended that appointment of a Committee to make a study of the special diet needs in anemia.

The Chairman of the Council appointed such a Committee with Dr. W. O. Thompson, Chairman.

Advisory Committee on the Medical Care of the Indigent and Recipients of Unemployment Relief.

Dr. Charles H. Phifer is Chairman of this Committee and has been since the Committee was first appointed in 1943.

Payments to physicians for the medical care of these recipients from the beginning of this project in 1943 to January 1945 amounted to $2,869,967.00.

Advisory Committee Cancer Prevention Clinic.

Dr. James P. Simonds is Chairman of this Committee.

The Cancer Prevention Clinic was established at the Women's and Children's Hospital and is the third one to be formed in the United States. There are only two other similar clinics, one in New York City and one in Philadelphia. This clinic is for women only and the medical services are rendered by women physicians who are members of the Chicago Medical Society. The purpose of this clinic is to discover cancer in its earliest stages. No treatment is administered at this clinic.

The Council in May 1943 appointed an Advisory Committee to the Cancer Prevention Clinic.

The Chicago Medical Society continues to progress and to function efficiently under the faithful guidance of our indefatigable Mrs. Fraser.

Respectfully submitted,
PERCY E. HOPKINS, M.D.,
OSCAR HAWKINSON, M.D.,
E. W. MUELLER, M.D.,
Councilors, Third District.

REPORT OF THE COUNCILOR OF THE FOURTH DISTRICT

To The Members of The House of Delegates:

The report of the Councilor of the Fourth District will be brief, emphatic and not idealistic.

Physicians in the Fourth District have been very busy. Those of military age are very few, and only a small number have returned to civilian practice from service. Consequently those remaining are all too few, tired, old, and yet, with but few exceptions, enjoying their busy practices.

There have been some physicians located in our District through the efforts of the state Office of Procurement and Assignment Service. This has been of great assistance to the community involved, and for the most part has been eminently satisfactory.

The deaths of members in this area during the past year have been above the average.

This District feels quite keenly the pressing need for constructive legislation for medicine rather than the continuance of the destructive attitude toward such legislation as has been introduced by well-meaning laymen. The need for some sort of prepayment plan for medical and surgical care on a voluntary basis and under the auspices and control of the profession, is evident. This problem has been studied seriously by at least some of the component societies in the Fourth District—especially by the Rock Island County Medical Society.

County society and other scientific gatherings have been less frequent than formerly. However, when held, they have been well attended and the spirit of those attending has been attentive, interested and even somewhat intense.

No particular problem of conduct of individual members or of policy for the component county societies has arisen during the last twelve months.

One of the younger physicians whose home is in our district and who has been in service with the Medical Corps of the Army, has been chosen as Pathologist to the Commission for the Study of Military Crimes Committed in Germany. At present he is in Paris engaged in this work.

One of the four Post-Graduate meetings scheduled for the 1944-1945 year was held in Galesburg on May 17. The meeting was eminently successful, and the outstanding feature of this post-graduate conference was the fact that the entire program was put on by the members of the staff of Mayo General Hospital. The willingness of these physicians, on active duty, to modify their procedures and their material so that it would be of interest and value to members of the medical profession in civilian practice is commendable and appreciated.

No new recipients of assistance from the Benevolence Fund have been added in this District, but all component society secretaries are requested to keep this phase of society activity in mind, and report any case worthy of consideration and investigation.

Several Fifty Year Club emblems and certificates have been presented, and in all cases the men so honored were still actively engaged in the practice of medicine, and were contributing to the maintenance of civilian health as their share in our nation's war efforts.

Respectfully submitted,

CHARLES P. BLAIR, M.D.,
Councilor, Fourth District.

REPORT OF THE COUNCILOR OF THE FIFITH DISTRICT

To The Members of The House of Delegates:

In the Fifth District conditions effecting the practice of medicine have changed little during the past year. In some counties one-half of the active physicians are in the armed forces. This has left a heavy load with added responsibilities upon the older members of the profession. They have met the situation in a satisfactory manner and the public has learned to be more tolerant of the doctor. So far as we know no one has suffered from lack of medical care.

A few of the smaller counties have had no regular meetings during the past year. In the larger counties regular meetings have been held with good programs but the attendance has been much less than usual.

There have been a number of deaths in the District and two of these have been among the men in service. In Sangamon County Lt. Anthony Kersotis died at sea. In McLean County Capt. Leroy W. Yolton was killed by a Jap bomb in February. This is the second death in the Philippines from McLean County as Dr. C. R. Kerr, Chenoa, died some months ago. Dr. Henry Aschauer, Dr. Robert Bullard and Dr. Martin Jelliffe, all of Springfield, have died during the year. Dr. Arthur E. Shell, Clinton, passed away several months ago. Dr. Harry L. Howell who had practiced in Bloomington for forty years died in December, 1944. Dr. Alvin Keller a former member of the McLean County Society, died recently in California as a result of an acute heart attack.

The movement in Washington to put the practice of medicine under governmental control has stimulated greater interest among physicians in legislative matters. One suggestion has been made that both the State Medical Society and the American Medical Association take a more aggressive part in matters of medical legislation and that we do not divide our influence by encouraging the organization of other groups whose chief object is to watch medical legislation. The opening in Washington, D. C., of an office by the American Medical Association has met with the hearty approval of the profession as a whole.

Respectfully submitted,

RALPH P. PEAIRS, M.D.,
Councilor, Fifth District.

REPORT OF THE COUNCILOR OF THE SIXTH DISTRICT

To The Members of The House of Delegates:

As Councilor of the Sixth District, it has been my pleasant duty to visit all but one of the County Medical Societies in that district.

Nothing of particular importance has occurred during the year in the district. Our tax-supported medical programs are functioning well and it is my feeling that most of the practitioners in the district are well satisfied with them.

We have two localities which operate under the old contract system. Needless to say, these are not satisfactory. In one instance, it is my opinion that the physician under contract is quite underpaid for the enormous work that he does. Indeed, I wonder sometimes how he can render efficient service under the circumstances.

While there is a widespread feeling that we are about to have socialized medicine forced upon us, few doctors, if any, are sufficiently interested to do very much about the matter so far as organized opposition is concerned. With the change of complexion of our present administration in Washington, I do not believe that there will be too much emphasis placed upon the legislation proposed in the past, at least, we can hope that there will not be.

During the past year, I was instructed by the Council to investigate the need for an Ear, Nose and Throat Service in downstate Illinois. Dr. Harry S. Gradle proposed that legislation be enacted enabling the present Trachoma Clinics to care for these indigent cases. Accordingly, I interviewed a sufficient number of downstate Ear, Nose and Throat specialists to convince me that there was such a need for indigent cases, and there being no objection to the proposal by the Ear, Nose and Throat physicians in the areas affected, I recommended that the Council endorse the proposal by Dr. Gradle. This was done in the way of a resolution and was adopted unanimously by the Council.

I have been interested in the organiaztion of a downstate Eye, Ear, Nose and Throat Society and am happy to report that such an organization has been effected and that we have held the first meeting, which was a grand success. The Society is now limited to fifty (50) members, but it is proposed to enlarge the membership, and suitable arrangements will probably be made to take in members from other than the downstate portions of Illinois.

It has been a great pleasure to act as Councilor of this district, and I have enjoyed my associations with the other Councilors at the regular meetings. In addition to my duties as Councilor of the Sixth District, I have acted as a member of the Board of Advisors to the Illinois Department of Public Health, and as an active member of the Sub-Committee of I. P. A. C. to administer the Blind Pension Program.

Respectfully submitted,

WALTER STEVENSON, M.D.,
Councilor, Sixth District.

REPORT OF THE COUNCILOR OF THE SEVENTH DISTRICT

To The Members of The House of Delegates:

The County Societies of the Seventh-Councilor District have furnished information from which this summary was obtained:

Number of Members	196
New Members	3
Deceased Members	12
Number in Military Service	65
Members of the Fifty-Year Club	9
Meetings Held—Scientific	32
Business	55
Average Attendance—Members	65%
Interest—Good.	
Post-Graduate Conferences, 1944	2

This record when broken down shows certain trends, first; the bottom of the barrel has been thoroughly scraped for available eligible men for the Armed Forces. Second; the average age of the 196 remaining members is 56 plus, which means the the older men and the physically disqualified for Military Service must carry the responsibility for administering medical aid to the public. Third; the faithful and efficient manner in which the older physicians have taken the responsibility reflects great credit on them as citizens and physicians. Their loyalty and patriotism is most commendable. The Councilor knows of no place in this District where the public is not getting adequate medical service and this is worthy of comment at this time. Fourth; the loss of 12 men in this District has been a severe one as a few of these men were active in the specialized fields and replacements have not been made. Fifth; the scientific programs have reflected a trend toward a better understanding of the social and economic problem confronting the medical profession, namely; proposal for statewide compulsory health insurance proposed under the Wagner Bill and sponsored by special interest groups. The Illinois State Medical Society should do everything within its power to keep the hands of politicians from controlling medicine in Illinois and in the nation. The educational campaign should be stepped up to awaken the people to the menace of political control. It has been my observation and conviction that the doctors have a proper role to play in the administration of voluntary health insurance and any good plan will give them that role. At the same time voluntary health insurance as a whole, must be of the people and for the people. The basic and over-all control must therefore remain with the public and not with any limited special interest groups. There should be a closer cooperation between the Council on Medical Service and Public Relations of the A. M. A. and the County Medical Society.

The care of recipients of Public Aid involving Old Age Assistance and Aid to Dependent Children and the Blind continues to be a subject for much discussion and differences of opinion. Cooperation with the I. P. A. C. has improved in this District by a better

understanding between the physicians and the I. P. A. C.

Your Councilor desires to express appreciation for the splendid cooperation he has received from the various County Societies within this District during the past year.

Respectfully submitted,

I. H. NEECE, M.D.,
Councilor, Seventh District.

REPORT OF THE COUNCILOR OF THE EIGHTH DISTRICT

To The Members of The House of Delegates:

There are no changes in the Eighth District to report during the past year. All counties having active societies are holding regular meetings, well attended and with interesting scientific programs, considering the fact that all home doctors are very busy. The hospitals are filled to capacity most of the time. Two special meetings were held when Dr. Pelouze was in the state with Dr. Cross; one at Mattoon by the Coles-Cumberland County Medical Society and one at Danville by the Vermilion County Medical Society. Both meetings were fairly well attended.

The care of the Old Age Recipients, Blind, etc., by the Illinois Public Aid Commission seems to be meeting with approval in the District, as it is better understood. Mr. Raymond Hilliard, Executive Director of the I. P. A. C., was in Danville in March and held a luncheon meeting with the local I. P. A. C., the Advisory Committee of the Vermilion County Medical Society and the local township Relief Committee. It was my privilege to sit in at this conference. I think everyone felt that Mr. Hilliard is making a sincere effort to carry out this work efficiently with fairness to all. Mr. Hilliard stated that in counties with active medical societies and an active Advisory Committee from the local medical society, the medical care of the non-paupers met with no difficulties. He stated that several counties did not have an Advisory Committee from the county medical society.

The Vermilion County Medical Society has had an active Advisory Committee since the relief work began. This committee has assisted the Board of Supervisors in checking up medical and hospital charges and since the Illinois Public Aid Commission has taken over the relief work, has cooperated in a similar manner. Dr. Harlan English who has been chairman of our county Medical Advisory Committee for several years is a member of the local I. P. A. C. and he is well informed about all relief activities. I have requested Dr. English to prepare a short report on the work of this Committee which is as follows:

"Beginning January 1, 1945, the Illinois Public Aid Commission, through its county department directors, attempted to take over providing medical care and hospitalization for old age assistance, A. D. C. and the blind group, on the basis of established fee schedules and a per diem cost of hospitalization.

"Our experience indicated that where the County Medical Society has an active advisory committee, the commission plan is workable. Where the county advisory committee is not active, there is considerable dissatisfaction.

"So far as hospitalization is concerned, the hospitals have so far preferred their usual ward rates plus charges for etxra service, rather than a flat per diem charge. From the administrative point of view, it seems to us that the flat per diem charge would tend to allow the recipients of Public Assistance more than the average patient gets, because of the illness that this group of people have.

"The settlement of claims, in the event of death, under the commission plan, in our experience, has been satisfactory.

"So long as the County Advisory Committee and the County Medical Society have a voice in the fee schedule, and review the charges submitted for medical care and hospitalization, the program will work. Whenever dictation comes in from the outside to the County Medical Society or the Advisory Committee, there will be trouble.

"Due to the war effort, many old age assistance recipients are now gainfully employed, but when the war effort relaxes, it is reasonable to anticipate that more recipients will join the rolls."

Reports of this type help to stress the need for better organized county medical societies. The doctors on the home front deserve much credit for their efforts in keeping their local society active. I wish to thank all the officers and members of the component medical societies in the Eighth District for their efforts to have an active society.

Respectfully submitted,

C. E. WILKINSON, M.D.,
Councilor, Eighth District.

REPORT OF THE COUNCILOR OF THE NINTH DISTRICT

To The Members of The House of Delegates:

During the past year, owing to the absence of many of the younger members of the profession with our armed forces, our medical meetings have not been as well attended as in former years.

However, the Jefferson-Hamilton, Williamson, Saline and Franklin Medical Societies have had regular meetings with good scientific programs. The Tri-County Society, composed of Massac, Johnson and Polk Counties, have had regular meetings with good scientific programs. Owing to the small membership in the other counties, they have had but few meetings, but have kept up their organizations and have attended scientific programs in adjoining counties.

One-third of the physicians in the Ninth District, which includes all the younger men of the profession, are with our armed forces, but no one needing medical care has suffered for want of same, as the older members of the profession have been on the job night and day and will continue their medical activities until the war ends.

One of the refresher courses sponsored by the Illinois State Medical Society was scheduled for Mt. Vernon on June 7th and a good attendance from the 9th and 10th Districts was present.

Respectfully submitted,

ANDY HALL, M.D.,
Councilor, Ninth District.

REPORT OF THE COUNCILOR OF THE TENTH DISTRICT

To The Members of The House of Delegates:

Due to the fact that a large percentage of doctors in our County Societies are in the Armed Forces, and due to the increased amount of work falling upon the shoulders of the older men, the activities in some of our County Medical Societies have been somewhat decreased; but notwithstanding this handicap many of our counties have been holding up to their average number of meetings and attendance.

The heaviest load carried by doctors in any county of the state is Perry, Tenth District, with a ratio of one doctor to each 3,500 population.

Our greatest worry has been to get replacement in some of our districts and our experience in some instances proved unfortunate, but the people of the community have been very patient and cooperative.

In this connection, I wish to suggest that influence be brought to bear on our Procurement and Assignment group that they recommend to the Surgeon General's Office that doctors being released from service be returned to rural areas where they are so badly needed.

We are indebted to the Medical Society of Randolph County for its recommendation on the care of the aged, who are chronically ill and who have been committed to the state institutions for the insane. This was called to the attention of the Department of Public Welfare, the State Judges organization, and also to the Central Service of the Chronically Ill. I am hoping that some legislation will be enacted that will give these unfortunates better care under more pleasant suroundings.

Due to the fact that most of the counties in this district adjoin Missouri and since that state has endorsed a prepayment plan for medical care, the doctors of this district are very anxious that our Society prepare and present a prepayment medical care plan at as early date as possible because they have already been approached to sign with the Missouri plan.

Respectfully submitted,

G. C. OTRICH, M.D.,
Councilor, Tenth District.

REPORT OF THE COUNCILOR OF THE ELEVENTH DISTRICT

To The Members of The House of Delegates:

Throughout this Councilor District the medical profession has maintained adequate medical care for the public. This has been accomplished in spite of the absence of at least one-third of their members serving with the armed forces. This is the most important duty of the membership back home and will be a source of great pride when the absentees return to active civilian practice.

Your Councilor has attended relatively few meetings of the component societies but has answered all requests for attendance and during the year has attended at least one meeting in most of the county societies. He finds that the work of the County Societies is being carried on well by the local officers, particularly the County Secretary, who is after all the leader of the medical profession in his locality. Fortunately, most of the secretaries have held their jobs for several years and are thoroughly conversant with the work of both the State and County Societies. This makes their work easier and assists the State Secretary with his work. Great credit should be and is given these men. During the past year the work on several Committees of the State Society, of which your Councilor is a member, has been very heavy, so heavy in fact that he has averaged a trip to Chicago at least once a week. This naturally has curtailed some of his other activities. The work of the Committee on Prepayment Plans for Medical Care and the Committee on Medical Care of Public Assistance Recipients has been particularly heavy and the attention of all members of the House of Delegates is directed to their reports included in the Handbook.

The Component County Societies have maintained a regular schedule of meeting monthly except in Ford, where there are so few doctors left that meetings are called as needed and in Will County where there is a noon meeting weekly. Attendance has been fair, but interest is well maintained and failure to attend is usually the result of lack of time instead of loss of interest. The maintaining of strong county organizations is most important at this time when there is such a constant discussion of State Medicine at Washington and in the press of the country.

The Councilor wishes to express his appreciation to the officers of County Societies for their activities the past year. He also wishes to thank the President and Secretary of the State Society for their cooperation in the past year.

Respectfully submitted,

E. S. HAMILTON, M.D.,
Councilor, Eleventh District.

REPORTS OF COUNCILORS AT LARGE

To The Members of The House of Delegates:

This has been an eventful year in medicine. Medical education has been curtailed. Medical meetings have by order of the Government been cancelled. Thousands of our members are in the Medical Corps of our military forces, distributed here and there all over the earth, each helping to protect the health of our armed forces, combat disease, repair injuries and conserve life, as well as helping to speed our fight for victory. Those physicians who have remained at home

have carried increased burdens. Their efficient protection of the health of the civilian population has helped to promote the war effort on the home front. We have been most fortunate in that we have not had an epidemic. Maximum employment in essential industries has reduced our relief rolls to a minimum. Prosperous times have prevailed. Hospital service plans have promoted a very active sales campaign for membership. The public has availed itself of this service. The scarcity of nurses for home care and the holding of hospital service plans have no doubt caused people to prolong their time in the hospital, thus making it difficult in many instances to obtain hospital beds for the acutely ill. This problem is not one of a deficiency of beds but rather one of prolonged hospitalization. This problem has and can be solved in most instances by the medical staffs of the hospitals daily checking their hospital patients and limiting hospitalization to those needing hospital care. It seems to me that the questions that concern most medical men today are the following: socialized medicine, prepayment plans for health insurance, the present and future supply of medical men, the reestablishment of our previous medical educational standards, the return to a normal allotment of interns and residents, the post-war medical education of members of the Medical Corps, the medical care of public assistance recipients, and the Hill-Burton hospital construction bill.

The question of socialized medicine is one that should concern not only every physician but every citizen of this nation. Great work has been done in educating the public relative to the kind of medical care the people will receive under socialized medicine. More educational work must be done relative to this problem, its type of care and its cost to the taxpayers. The reports indicate that Senator Wagner is preparing to introduce a revised edition of the Murray-Wagner-Dingell bill. It is generally believed that with numerous changes there will be added provisions for old age survivors and benefits for domestic and farm employment and other categories. The ninth annual report of the Social Security Board and Congress states that while there are at present about 35,000,000 persons protected under various forms of hospital and prepayment plans, they are inadequate and do not meet the economic individual independence which our national resources should provide. It is also more than probable that bills will be introduced in Congress to provide for subsidies for research. This would be most unfortunate as it would tend to discourage physicians with initiative and qualifications for research and no doubt destroy the present high grade research that is carried on by individual scientists. This legislation is a constant threat to free enterprise in medicine and requires the continued attention of every physician.

The past year has seen much activity throughout the nation in reference to prepayment plans for health insurance. It is to be noted that some states have pioneered on this subject for several years. There is today much activity in regard to studies by the different state medical societies relative to the problems within their states. The needs and practical applications of such plans vary with the individual states, their populations, and their employment and unemployment. Every physician should familiarize himself with the different types of prepayment plans for health insurance. He should know that the House of Delegates of the American Medical Association has recomended for a number of years that hospital service plans not include medical care. He should know that the Blue Cross Plans covering hospital service have been actively engaged during the past few years in promoting extensive sales for hospital service, that the Blue Cross Plans to include x-ray, pathology, and anesthesiology regardless of the fact that the House of Delegates of the A. M. A. has not countenanced their inclusion in hospital service. The prepayment plans for health insurance have generally been of two types, those of a service rendered basis in which there is a certain fee allowed for medical care regardless of the amount of work that is done. These fees are similar to those allowed under the Workmen's Compensation laws. In some instances this type of payment applies up to a certain income, say $2,500, and over that income the plan may become an indemnity type of plan in which the payment for medical service applies as an indemnity on the charge for medical service, the physician making his own arrangement for the fee and the payment simply applying on his total charge. The past experience with most of these plans has been that medical care has been a harder problem to estimate than that of surgical or obstetrical care. Some of these plans have been financed by the medical society, others have been aided by private citizens. A few plans are on a statewide basis, some on a county basis. The State Committee for the Study of Prepayment Plans for Hospital, Medical and Surgical Care has devoted much time and study to the medical plans in the nation, as well as to the existing plans among industries and the medical needs of the State of Illinois. They will make a separate report to which I direct your attention.

It seems to me that the present and future supply of physicians is a matter that should seriously concern the medical profession as well as the citizens of this country. The war has greatly altered the pattern of medical education. If it is not changed in the near future it will ultimately have a grave effect on the type of the future medical care of this nation. The annual pre-war medical requirements for our country were about 6,000 medical graduates. These were needed to furnish the yearly quota of interns and residents and help fill the replacements due to retirement and death. The government early recognized the great need for continuous production of physicians. It made provisions for the education in its specialized training program. It likewise provided for Selective Service to defer students who had proper educational qualifications to study medicine. This specialized training program discontinued its medical program July 1, 1944,

thus stopping any future recruiting of physicians from civilian life. The V-12 (Navy) will have for a limited time a few students within its ranks that will be enrolled in medicine this fall. It is thus evident that except for the students that are now going through meical school there is no provision at the present time for keeping a sufficient number of medical students in college to provide for the medical needs of our nation. The marked effect of this restriction will be seen in the classes matriculating in medical colleges this fall. In some classes the V-12 will constitute about 25 per cent of the enrollment. The remainder will be made up of physically disqualified students (4F) and women and possibly a few members of the military forces returned from service. All medical colleges have adopted a uniform policy in that beginning this fall they will have but one annual matriculation. It is to be noted that after the students have enrolled the accelerated program will continue with that class until it is graduated. Numerous attempts have been made to have Selective Service reconsider its ruling opposing the deferment of students to study medicine, each unsuccessful. Congressional legislation was introduced last year but did not become a law. Legislation is now pending before Congress, introduced by Senator Allen J. Ellender; Senate Bill 637 includes provision for the deferment of adequate number of premedical students for a period of two years and it further provides for the deferment of medical students as will be sufficient to supplement civilian sources of students for the maintenance of full classes. This bill should be enacted into our laws. It has been referred to the Committee on Military Affairs of the Senate. It should be supported by the members of the medical profession, hospitals and medical schools.

The question of returning to our normal allotment of interns and residents as well as the total amount of time allowed for training will in all probablity only be changed when the demands of our military forces diminish for military replacement and the number of our medical students is increased to meet the medical demands of our country. The shortage in interns and residents is a serious problem. The hospitals are filled to capacity. The doctors are overworked. The intern and resident fill a very important role in the medical care of the civilian population while they are in the hospital. The lack of a sufficient number of interns and residents seriously curtails medical care. Many hospitals at the present time have had their house staff of interns and residents cut to a minimum and some are without this type of service. This depletion also sadly alters the fine type of training that American Medicine has devised for qualifiying physicians in the various specialties.

The question of post-war medical education of returning members of the Medical Corps, is a very important project. Many of the younger men in service have had their internships shortened and there have been few residencies during the time of the war. These men have all made great sacrifices not only in education but in the time spent in military service. They are entitled to every opportunity that can be provided for them to help complete their training. The Committee in charge of this program has done an excellent piece of work not only in the inquiry of the type of training that the members of the Medical Corps desire but in accumulating lists of all institutions where such training can be given under proper conditions.

The medical care of recipients of public assistance, especially those qualifying under Social Security law, continues to be a problem that needs careful study and consideration by the members of your State Medical Society. The load has been somewhat reduced in numbers during the past year for the reason that some recipients secured employment in war efforts. This reduction no doubt is temporary and the case load will again reach its previous records. The majority of physicians in the state have been very considerate of the problems that arise in the medical care of these recipients under the Social Security law. They have been most cooperative and have made every effort to try to give adequate medical care regardless of the fees allowed and the administrative handicaps. Your Medical Advisory Committee has devoted many hours in the interest of the health of these recipients, the interests of physicians, and the conservation of public funds. It is my impression that much has been accomplished in simplifying the rules and regulations in the reporting of these cases. There has also developed a better working relationship and understanding between the local representatives of the administrative agency and the members of the medical profession. There is a great probability that the number of categories that will benefit under the Social Security law will be greatly increased in the future. I appreciate the fact that many of the problems associated with this program are controversial. There has been a fee schedule devised for this program in our state that is comparable with other states for this type of recipient. It is true that these fees do not compare with those customarily charged to wage-earning people. They are comparable to those allowed under the Workmen's Compensation Act. They compare favorably with many of those allowed under some types of medical service plans. There has been a tendency on the part of certain counties in the state to feel that the members of their medical group were entitled to more compensation than the state schedule of fees provided. I am, however, certain of one thing, that the grants these people receive are uniform throughout the state. The schedule of fees should also be uniform all over the state. It is obvious that the physicians in Cook County should not be asked to tender medical service gratuitously and the physicians in the remainder of the state be paid for their services. Neither is it fair for the physicians in one county to be entitled to a higher schedule of fees than the state program provides. There should always be provisions for the patient to have a free choice of physician. The program should be open to all physicians in the state. It should, however, be the privilege of the physician to elect whether he

cares to participate in the program or not. I sincerely hope that these thoughts will always pertain to the operation of this program. Much thought has been given by your Committee as well as by many members of the profession as to how the provision for better medical care of these recipients can be improved within the present limitations of the Social Security Law. It is interesting to note that recently Dr. Miller, a member of Congress from the State of Nebraska, has introduced in Congress House Bill 1442 pertaining to this problem. This bill would amend the Social Security Act so as to aid the states in providing certain medical, surgical and hospital care. He feels there is little uniformity in regard to appropriations by the states for the medical care of these recipients. That the amount of money is generally too small to provide medical service in an adequate way. His suggestion is that the states should contract with insurance companies to provide the service. He suggests that insurance schemes should be developed in a manner somewhat similar to those under which our Workmen's Compensation laws are operated. This bill has been referred to the Committee on Ways and Means.

The members of the medical profession should give very careful consideration to the Hill-Burton Construction Bill. This proposed legislation may be constructive or destructive. There is no organization that is more able to pass upon the community needs for medical care, hospitals or the number and type of hospitals required than are the members of the State Medical Society. They should as members be familiar with the distribution of medical care in their respective states and the hospital facilities required to protect the health of each community. This legislation is designed for appropriations for hospital facilities. It is reported that the funds primarily provided will no doubt be used for surveys of hospital facilities, paying the expenses thereof, and purchasing of hospital sites. There are at this time attempts by various groups to interpret into this bill provisions for the chronically ill and current illness. This bill is implemented by recommendations of Surgeon-General Parran and the Senate Service Committee on Wartime Health and Education. It is the belief of many that the expansion of the Social Security program will have immediate attention after recommendations and adoption of the above bill.

In this connection it is interesting to note that the American Hospital Association recomemnded to Congress the following action by the Federal Government which would encourage voluntary effort to accomplish adequate distribution of hospital care, since they are consistent with the unmet needs and available resources of the United States. It is stated that they recommended first grants and aids to the states to provide hospital care for beneficiaries of public assistance recipients and other medically indigent members of the population; grants and aids to states for hospital construction in areas requiring such assistance, and because of low incomes or critical shifts in population. Such grants should in general be made for the expansion of existing institutions rather than the establishment of new hospitals. Expansion of existing social insurance benefits to employees of non-profit institutions and other groups desiring benefit of coverage. Permission for payroll deductions for Federal employees participating in voluntary hospital service plans.

It is impossible for any of us to discuss the medical problems of today constructively without reviewing the effects of the recent social and economic upheaval in this country and its effect upon these problems. It is imperative that we fully realize the many changes that have occurred in recent years in the public welfare organization throughout this great nation. In this interim we have seen it changed from a small business into one of the largest organizations in this country. It now affects a very large proportion of our population either as recipients or as tax payers, and likewise enters into most medical questions. It is gratifying to note that American medicine has tried to provide good medical care to all people regardless of their financial status in life, and there can be no question that it will so continue as long as the art and science of medicine are practiced.

In the interim since I became president-elect of this Society it has fallen to my responsibility to be chairman of two very important commitees of the Council, namely, the Medical Advisory Committee for Public Assistance Recipients and the Committee to Study Prepayment Plans for Medical and Surgical Care. It has been my good fortune to have assigned to each of these committees distinguished physicians who not only have been greatly interested but well informed on the problems concerned in each of these assignments and their practical application to the practice of medicine and the public. I want to acknowledge my great appreciation for assistance to Drs. E. S. Hamilton, Julius H. Hess, James H. Hutton, E. P. Coleman, H. M. Camp and P. E. Hopkins as members of the Medical Advisory Committee, and to Drs. Frank Deneen, Robert W. Keeton, Richard J. Bennett, E. S. Hamilton, J. H. Chivers, C. P. Blair, Robert S. Berghoff, Percy E. Hopkins, E. P. Coleman, H. M. Camp, and Mr. John W. Neal, as members of the Committee to Study Prepayment Plans for Medical and Surgical Care.

This report concludes my term as Councilor-at-Large. I have greatly enjoyed the honor and distinction that your House of Delegates conferred upon me in making me president of this Society. It has been a privilege and a pleasure to know the members of this great Society and to work with them and with the Council in helping to adjust some of the problems confronting our great profession. The work in the Council has been a pleasure. I have enjoyed knowing what the medical problems are in the different councilor districts and in trying to help adjust them. I shall always treasure the friendships and associations that I have made as an officer in this Society. I assure you of my continued interest and willingness to

help if and when I can be of assistance to our organization.

Respectfully submitted,
CHARLES H. PHIFER, M.D.,
Councilor-at-Large.

To the Members of The House of Delegates:

I have attended all the meetings of the Council and a few special meetings. I have also attended a few County meetings in the northern part of the State and I am glad to report that the activities of the Medical Society have gone on in about the usual manner. The attendance is not as large as it was, but on the whole there is probably a higher percentage of attendance than in years gone by.

There are a number of counties with only a few physicians in various parts of the state that do not hold regular meetings. This is not as it should be and I feel that a greater effort can be made to hold regular meetings at every County Society. There is nothing to prevent two counties joining together for a combined meeting. Speakers can be secured and notices sent out for the meetings from the educational committee. Our Medical Society is built from the ground up and depends for success upon the foundation that the county societies make for it.

The criticism and suggestions of the County Society are always welcome. Many of the problems for discussion can be found in the section of economics in your state journal. This year more than ever before the medical societies must be on guard, first to know what they want, and second, to let your representatives, both in your medical societies and in your Congress know of your desires.

It has been a great privilege to serve as your Councilor-at-Large and I want to assure you that I am more than happy to do everything I can to assure the best possible medical practice.

Respectfully submitted,
EDWARD H. WELD, M.D.,
Councilor-at-Large.

REPORT OF THE EDITOR

To The Members of The House of Delegates:

The Illinois Medical Journal has weathered another stormy war year since the last annual report of your Editor was submitted. Once more we desire to state that we have had some trouble with the paper shortage and have had to cut down a few pages for an occasional issue, yet we have endeavored to carry the usual number of scientific articles in addition to the several departments which have been approved by the Council Journal Committee and Editorial Board.

There has been a delay in getting recent numbers of the Journal to the members of this society largely due to labor shortage in the plant where our Journal is printed. We must continue to be patient for the duration. Then we hope to have the Journal out each month on regular pre-war schedule.

During the past year we have had joint meetings of the Journal Committee and Editorial Board with the Editor and Business Manager present to discuss many problems in connection with the Journal. Some advertisements which were considered questionable were eliminated but we have had no trouble whatever in getting all desirable advertising contracts which could possibly be used, for after all, the primary purpose in publishing the Illinois Medical Journal is to get scientific articles and other data of general interest to the members of this Society.

There have been several changes in the set up during the past year. At the suggestion of the Council, then later approved by the committees, a department was made available to the Director, Illinois Department of Public Health, where information concerning the work of that State Department is being presented each month. Another new venture is the department where abstracts of recent literature on physical therapy are presented each month under supervision of Dr. John S. Coulter.

In order that as many news items concerning Illinois physicians and the component societies as possible may be published regularly, the "News of the State" section has been greatly enlarged during the past year. Component society secretaries and other members having news items of interest relative to Illinois physicians should submit them promptly to the Editor for publication in this department of the Journal. We are always desirous of receiving information pertaining to the activities of Illinois physicans with the Armed Forces which is always of interest to our readers.

With the cancellation of the Annual Meeting for 1945, your Editor will greatly appreciate receiving scientific papers, interesting case reports and similar data for publication in the Journal, as we will not have the usual number of annual meeting papers for publication during the coming year. Fortunately we do endeavor at all times to keep a liberal supply of timely scientific papers for several issues of the Journal in advance, and it is highly essential that we continue to do so in months to come.

During the past year it has been more difficult than formerly to route the Journal for the many hundreds of our members overseas, but in all instances where proper mailing addresses have been given, we have sent the Journal to each member every month. One complaint frequently received from men in service is the fact that often they fail to receive their Journal monthly, but perhaps will receive four or more in one mail, and this through no fault of the Journal force. With the end of the war on the European front and the deployment of troops and personnel to the Pacific areas, it is quite probable that mail shipments of Journals will be speeded up, and there will be less delay than has been the case in the past.

We have received quite a number of papers and most interesting case reports from men with the Armed Forces, and most of these have been published. Those of our members in service who read this report may be assured that we always welcome the receipt of papers or case reports as well as any in-

formation concerning their whereabouts and activities that they are permitted to send us.

Many stories will be told after the war is ended which will be of great interest to the American people, and among these will be stories concerning the activities and work of the Medical Corps and their accomplishments. We sincerely hope that many of our service members will keep accurate notes and eventually submit their stories in much detail for publication, perhaps in an issue of the Journal dedicated solely to them.

The Illinois Medical Journal is the official Journal of the Illinois State Medical Society, and is owned by the members, published under direction of the Council and under the supervision of a Journal Committee and Editorial Board. All of the above, with the Editor and Business Manager, are desirous at all times of publishing what you, the members and owners of the Journal, desire to have published. Criticisms are always welcomed, constructive or otherwise, but we will be better enabled to tell what you want if you will submit your suggestions, or criticisms.

We hope that by the time the next Annual Meeting is scheduled, the war will be over and our component societies and their membership will be returning to normalcy. Reports of the activities of all component societies should appear in abstract in the News of the State, and again we ask that each of you endeavor to submit all data of general interest to your Editor and his assistants promptly and regularly.

In closing, it is the desire of those responsible for the publication of the Illinois Medical Journal to thank all members of this Society for their splendid support and encouragement, and we hope that when paper shortage is relieved and censorship bans removed, we may have the type of journal that is most desired.

Respectfully submitted,

HAROLD M. CAMP, M.D.,
Editor.

Reports of Constitutional Committees

REPORT OF THE COMMITTEE ON MEDICAL SERVICE AND PUBLIC RELATIONS

To The Members of The House of Delegates:

This committee was created by the Council in June, 1944. Its purpose is to effect closer relations between our Society and the American Medical Association Council on Medical Service and Public Relations. The latter is largely an information agency. It has an office in Washington, D. C., in charge of Dr. Joseph S. Lawrence. That office furnishes to the profession information regarding activities in Congress and furnishes to members of Congress, who ask for it, information as to the views and practices of the profession.

This committee has handled various matters relating to the public and the profession. In December, the chairman, Mr. John Neal, and Dr. Harold Camp attended a regional conference in Kansas City, between representatives of the Council on Medical Service and Public Relations, the American Medical Association headquarters staff and men from Illinois, Missouri, Kansas, Arkansas, Oklahoma and Texas. Half of that day was spent in discussing plans for the prepayment of medical care. This subject has been studied extensively and exhaustively by a special committee created by the House of Delegates at its meeting last year. The findings of that committee will be reported by its chairman, Dr. Charles H. Phifer.

The Committee on Medical Service and Public Relations has had assigned to it various tasks that did not specifically fall within the duties of other committees. It has tried to keep abreast of developments in our own legislature and in the national Congress. These summarized in the following paragraphs.

With the Illinois General Assembly in session since last January, a considerable volume of legislation pertaining to public health and medical practice has been introduced, varying in quality and merit from highly undesirable to most excellent. As of the date of this writing, it is surprising and gratifying that only one of the customary "cult bills" has been introduced (H. B. No. 389, providing for the establishment of a separate board for the regulation, examination and licensure of chiropractors.) In other years, four or five such bills have been "in the hopper" at this stage of the session.

For the most part, the pending bills of medical significance deal with post-war problems of public health and veterans' care and rehabilitation. Measures have been proposed to build ten state veterans' hospitals; to provide State aid in tuberculosis control by paying a subsidy of $1.50 per patient per day to accredited institutions caring for tuberculosis sufferers; to use State funds to care for typhoid carriers who agree to isolate themselves and thus minimize the exposure of others; to build a State Cancer Hospital; to regulate hospitals and related institutions by requiring them to be licensed by the State Department of Public Health; to place sulfonamides and certain other potent drugs under prescription. Among the particularly undesirable bills are those designed to regulate chiropractors; to permit drugless healers to treat Old Age Pensioners; to make it unlawful for a physician to decline treatment in cases of accident or severe injury; and to give a patient title and the right of possession to all X-rays taken of him. Of particular interest also is a measure proposing the creation of a Commission to survey the State's needs for medical and hospital care, and to report back to the next General Assembly "concerning the establishment of a State system of hospitalization and medical care." Bills actually proposing state medicine have been introduced into the legislatures of several states this year, but to date, no such proposal has been made in Illinois.

The medical profession continues to enjoy the good will and respect of a great many of the State legislators, but in such matters there is always room for im-

provement. The preservation and betterment of that good will is of necessity a never-ending process. Only by constant and continual contact between physicians and legislators can the latter know what the profession is doing along scientific and economic lines, and what its thoughts and wishes are in matters of interest to it. County Medical Societies, and the individual members thereof, are best situated to do the job of public relations which must be done with our lawmakers, if the American System of Medicine is long to be preserved.

Upon the national scene, the Wagner-Murray-Dingell bill remains the most important single piece of medical legislation. It is rumored that a revised draft of the bill will soon be offered by Senator Wagner, designed to meet some of the objections made to the original measure. At this date, however, there can be no certainty as to when or whether a revised bill will be presented, or just what its provisions may be. Other pending federal bills would create a Department of Health whose secretary would be a member of the President's cabinet; to defer an adequate number of medical and premedical students; to restrict animal experimentation in the District of Columbia; and literally dozens of other matters. This committee has attempted, in the field of federal legislation, to cooperate with the Council on Medical Service and Public Relations of the American Medical Association.

Respectfully submitted,

JAMES H. HUTTON, M.D.,
Chairman.
E. P. COLEMAN, M.D.,
HAROLD M. CAMP, M.D.,
EDWIN S. HAMILTON, M.D.,
R. S. BERGHOFF, M.D.,
JOHN W. NEAL.
Executive Secretary.

REPORT OF THE COMMITTEE ON PROFESSIONAL DEMEANOR

To The Members of The House of Delegates:

This committee has noted the past year, a great decrease in the number of malpractice suits instituted against our members. We have no means of knowing what legal actions actually are in progress since not all come to our attention; however, the past year the number we have been called upon to assist is approximately 50 per cent less than that of 10 years ago. Several reasons for this change could be mentioned; first, financial aid to our members has been discontinued; second, the committee name has been so altered that direct relation to Medico-Legal defense is not always clear; there might be question as to whose professional demeanor is being investigated.

The need for malpractice insurance seems to have made itself more clearly felt with the passing years. Ten years ago it was thought that about 40 per cent of the doctors in Illinois carried insurance covering suits for malpractice; conclusions being drawn from the cases which came to our attention. Inquires from some of the larger companies at this time seem to indicate that since the State Society discontinued its defense of our members, there has been an increase of 15 to 20 per cent in the number of those carrying Liability Insurance; most companies providing Liability Insurance, require that the insured be a member of his local Medical Society; this policy was subjected to a great deal of criticism a few years ago, when some men assumed the attitude that in this way, pressure was being made to compel them to join the society. Fortunately this feeling has now practically disappeared, and a few companies do not require such membership.

It is a well known fact that suits and threats are most likely to come from directions least expected, and it is very easy for one listening to complaints by word, act, or even silence to stimulate a suit for malpractice.

The members of the Illinois State Medical Society are fortunate in being able to secure from high grade companies, protection at such moderate cost, and it would seem the part of good judgment for everyone to avail himself of such insurance.

Respectfully submitted,

OSCAR HAWKINSON, M.D.,
Chairman,
A. L. NICKERSON, M.D.,
P. R. BLODGETT, M.D.,
T. B. WILLIAMSON, M.D.,
D. B. POND, M.D.,
RALPH McREYNOLDS, M.D.,
Committee on Professional Demeanor.

REPORT OF COMMITTE ON MEDICAL BENEVOLENCE

To The Members of The House of Delegates:

This report covers the period from May 1, 1944 to April 30, 1945.

There were ten recipients of assistance during the fiscal year. Two recipients died and two new ones were added during the fiscal year. The total amount paid out by the society was $2,250.00.

It is the opinion of the Committee that it should be noted with gratitude that the Woman's Auxiliary to the Illinois State Medical Society paid in $1,305.90 to the fund during the fiscal year.

Your Committee is of the opinion that when the present lush period comes to an end the call for benevolence will be much greater than it has been during the last year.

Respectfully submitted,

G. HENRY MUNDT, M.D.,
Chairman,
C. H. HULICK, M.D.,
H. M. CAMP, M.D.
Committee on Medical Benevolence.

Reports of Council Committees

REPORT OF THE EDUCATIONAL COMMITTEE

To The Members of The House of Delegates:

The functions of the Educational Committee are comparable to the kaleidoscope. The varied types of activities of the Committee correspond to the kaleidoscope's loose fragments of colored glass, all planned and arranged to develop a symmetrical pattern of health education.

It is difficult, in an annual report, to develop these bits of colored glass. Figures cannot give the whole picture as the seemingly routine work of an office of this kind is too wide-spread in its influence. The following is an illustration: The health chairman of an organization came to the office to inquire about a speaker for a meeting. She went away with the assurance of having the program on the date selected and also with copies of material on health topics for distribution at this meeting. After the meeting was held, those hearing the talk, received the literature to take home. As a result of this one woman's visit to the office of the Educational Committee, many new contacts were made and a number of new names were added to the mailing list to receive material as released. Not one, but many have become acqainted with the Illinois State Medical Society and its program of public education through this type of service in the office of the Committee.

NEW PROGRAMS

Every year the Committee has tried to develop at least one new feature. This past year THREE important programs were inaugurated and they will be continued and enlarged.

1. INDUSTRY—

The Committee for a number of years has furnished material, which it calls DO YOU KNOW, to industrial organizations of the state. Many plants use this material on bulletin boards and in others the medical and nursing departments are responsible for disseminating the information to employees. Last fall the Committee obtained a copy of a current directory of house organs published by industrial organizations in Illinois. A letter was sent to the editors of these various publications offering to supply them with a health column on topics which would be of particular interest at all seasons of the year. These publications are distributed to thousands of employees every month.

40 Industrial organizations requested the material for publication and the following comments attest the need and appreciation:

Accurate Spring Mfg. Co.—"We feel that these releases are of great interest to our employees and are looking forward to receiving the future releases."

Admiral Corporation—

Allied Steel Castings Co.—"We are very much interested in the releases on popular health topics of current interest prepared by the Illinois State Medical Society."

Armour & Company—"Please place us on your mailing list for popular health topics of current interest."

Beaumont Electric Supply Co.—"We gladly accept your offer and thank you for this service which we feel will be beneficial to our workers and their families."

Bowman Dairy Company—

Chicago Mail Order Company—"We shall be happy to use these in our publication."

Chicago Park District—

Chicago Title & Trust Co.—"We would appreciate your placing us on your mailing list."

C. P. Clare & Co. (Electro-Mechanical Specialties)—"We will be very glad to receive these releases on popular health topics."

Container Corporation of America—"We would appreciate your releases on popular health topics and request that you place our publication on your mailing list."

Continental Casualty Company—

Dadant & Sons (Bee-Comb Foundation)—"We would appreciate your putting our company on your mailing list."

Eicor Inc.—"Thank you for your letter of November 30. I believe we can all benefit by your kind thoughtfulness in supplying us with material on health, especially in these times when absenteeism is so vital to the war effort."

Electric Research Laboratories, Inc.—"We would like very much to be put on your mailing list for releases of popular health topics."

Gits Molding Corporation—"The two releases enclosed with your letter are very interesting and, I am sure, very beneficial. This is a very fine public service, and we are glad to be able to take advantage of it."

Goodman Manufacturing Company (Electric mining machinery)—"We would appreciate the material."

Grover Tank & Mfg. Co., Inc.—"Please include the name of our employee magazine on your regular mailing list for material pertaining to health, precautions and informative news."

Industrial Casualty Insurance Company—"We will be pleased to use your releases as they come out."

Jewel Tea Company—"Please send the material. It is good and we should like very much to be put on your mailing list."

Johnson & Johnson—"We would like to be put on your list."

Liquid Carbonic Corporation—"Material of this type is beneficial for general reader consumption and should be especially applicable to house organ circulations."

Lion Manufacturing Corporation—"The sample press releases on popular health topics have been reviewed by us with great interest and we would like to be placed on your mailing list."

Minneapolis Honeywell Regulator Co.—"Thanks much for your offer to send us releases prepared by your Society, we shall be very happy to receive them."

National Confectioners' Association of the U. S.—

"We shall be very much interested in receiving your releases on health topics of current interest."

Perfecting Gear Co.—

The Pullman Company—"From time to time we publish health stories in our house organ, 'The Pullman News,' and will be glad to receive your releases."

Pfaelzer Brothers—"I will be very happy to receive this service."

Pullman-Standard Car Manufacturing Co.—"The releases that we received were very interesting and we believe that they would be very beneficial to our employees. We would like to be placed on your mailing list as soon as possible."

Rheem Manufacturing Company, Inc.—"We would appreciate your sending two copies of each release to Mrs. Murvihill, R. N., of our Medical Department. She will in turn forward one copy to our plant located at 3425 South Kedzie Avenue, Chicago."

Sally Frocks—"We would be very happy to be placed on your mailing list for releases on public health topics. We will, of course, give credit to the Illinois State Medical Society."

J. P. Seeburg Corp. (Musical Instruments)—"We are interested in receiving your releases."

A. E. Staley Manufacturing Company—"We used your samples and not to fill up space either. We could often use an article from your office."

Stewart-Warner—Green River Ordnance Plant—

Swift & Company—"I would be glad to have you add my name to your mailing list providing your letter means what it says when it describes these articles as 'of current interest.' The reason I say this is that our only other source of material of this kind is the American Medical Association News. We find in it much too often material of a technical nature that will not lend itself to a publication such as ours. The sample article on 'The Common Cold' which accompanied your letter appears to me as being the type of material I can use and I trust that other releases will deal with other subjects in as clear and concise a manner as does this one."

United Parcel Service—"I should appreciate material. Credit will be given to the Illinois State Medical Society for all material used and a copy sent to you of each issue."

Webster Products—"We would appreciate receiving releases."

Western United Gas & Electric Co.—"We shall be glad to be placed on your list."

2. SCHOOLS:

Early in September a letter was sent to principals of downstate schools offering package libraries and the DO YOU KNOW column to teachers responsible for carrying on the health program as outlined in Senate Bill 396.

100 Package libraries were prepared and loaned at the request of health and biology teachers.

500 Teachers requested that they be placed on the mailing list to receive the releases. At the present time approximately 750 Illinois teachers receive the material released by the Educational Committee.

Some of the teachers receive from 5 to 50 copies of the material for distribution to all teachers in their schools. One school asked for permission to mimeograph 100 copies of each article. The High School at Evanston wrote, "During the past school year we have received mimeographed copies of your releases for our faculty members. The entire faculty has been very appreciative of these helpful bulletins. I would appreciate continuance of this service this coming school year. Our faculty numbers 150."

One of the Health Consultants with the Office of the Superintendent of Public Instruction wrote, "Will you please place me on the mailing list for your health reprints and do you have anything on the two following subjects that would be suitable to give to High School students? One is, 'How to Find and Use the Expert Advice by Physicians and Hospitals.' The other is, 'How You Can Help Your Doctor in Wartime'."

A college professor wrote, "Could we have copies of your regular monthly bulletins for a class of 40 prospective teachers."

The Committee has always felt that the teaching profession could play an important role in health education. Certainly progress is being made along this line.

Last summer 47 trainees in health education doing field work under the supervision of the U. S. Public Health Service spent five days of intensive observation and demonstration work in health education and studying the organization and work of the American Medical Association. The work of the Educational Committee of the Illinois State Medical Society was included in the course and was presented by Doctor James H. Hutton.

3. LECTURES AT MUSEUM OF SCIENCE AND INDUSTRY, CHICAGO:

Dr. Eben J. Carey, Director of Medical Exhibits at the Museum of Science and Industry, thought that the thousands of people going through the Museum might be interested in hearing popular health lectures. Last summer four programs were given on Friday evenings by members of the Chicago Medical Society. These lectures were well attended and created so much interest that Dr. Carey asked for another series to be given on Sunday afternoons during the late fall and winter. It is hoped that this type of program may be widely developed during the coming year.

The Educational Committee not only secured the speakers for these lectures but also sent out 950 announcements of the programs.

REPORT OF WORK ALREADY ESTABLISHED STATE LEGISLATORS:

The Committee placed the names of all legislators in Illinois on its mailing list and has kept the list up to date following elections, and many of those men who were not reelected last fall have requested that their names be retained on the mailing list. One Representative wrote—"For some time I have been receiving your literature on DO YOU KNOW, and do you know that I find them very good, informative, educational, instructive and in easy to understand plain horse

sense language. Allow me to congratulate the Society on this fine work. I have a special request to make and if it cannot be done, it's O. K. by me. I would appreciate as many as possible of the back releases so that I may be able to put them in book form for my own use, they make such fine, easy reading for anyone coming into my office. Might I suggest, it wouldn't be a bad idea to put them in book form." Here is another bit of colored glass in our kaleidoscope!

FIRST AID ARTICLES:

The Chicago Sunday Tribune of December 9, 1944, carried a story by Gail Compton, following an interview he had with Dr. Camp. The story referred to the set of articles, "Leave 'Em Where They Lie," which were released some months ago by the Educational Committee. As a result of this story the Committee received requests for the articles from 400 persons from all sections of Illinois, Indiana, California, Minnesota, North Dakota, Florida, Iowa, Wisconsin, Michigan, Nebraska, Ohio, Missouri and Kentucky.

PACKAGE LIBRARIES:

Calls came in almost daily for loan of the package libraries. This has been a real service to high school and college students, teachers and club women as well as to doctors who were asked to speak to lay audiences. A member of the Illinois Federation of Women's Clubs has used a number of the packets and reported, "You are certainly doing a fine work. Our whole club send their thanks."

SOCIALIZED MEDICINE:

There is wide spread interest in the subject of socialized medicine. The office of the Committee has furnished many package libraries on the subject and has assembled material for distribution to many groups. Copies of articles on this topic have been enclosed with the DO YOU KNOW column going out to several thousand citizens of Illinois. Speakers have been scheduled to present the viewpoint of organized medicine and Mr. Neal has cooperated by taking many of these assignments.

Speakers have been scheduled to participate in a number of forums on Socialized Medicine.

Copies of the pamphlet, "Private Practice of Medicine," were sent to all schools.

Special material on the subject was compiled for the headquarters office of the Illinois Federation of Women's Clubs.

Package Libraries of material on socialized medicine were sent to college students and teachers.

EXHIBITS AND FILMS:

The Committee obtained a list of films and sources of health education material from the American Medical Association. Mimeographed copies were made and sent to all county medical society officers and to all teachers on the mailing list.

Films have been ordered from the State Department of Public Health for various organizations and copies of their film list and other materials were sent to club chairmen.

Exhibit material was obtained for the Fulton County Health Department. The subjects of cancer and syphilis were portrayed in window exhibits through the courtesy of the American Medical Association and the Field Army of the American Cancer Society.

SPEAKERS BUREAU:

The Committee has attempted to fill all requests which came in for doctors to address lay audiences. Due to the shortage of physicians the Committee has not emphasized this part of its program during the last two years. Contact, however, has been kept with lay groups so that this service might be resumed and increased after the war.

Speakers were scheduled for business men's clubs, women's clubs, Parent Teachers Associations, nursing groups, schools, laity meetings of the Woman's Auxiliary.

Youth Week, which is observed the last of April, brought in many requests for doctors to address school assemblies. Audiences ranged in number from 200 to 1500 children. Excellent reports were received from principals.

Assistance was given leaders of the Illinois Congress of Parents and Teachers in arranging three panels, two in Chicago and one in Springfield, for health and summer round-up chairmen of the Congress. These meetings were well attended and the programs and speakers proved highly satisfactory.

The public realizes that doctors are extremely busy and overworked and appreciates the willingness of so many of them to give their time to present these interesting lectures.

CANCER EDUCATION AND INFANTILE PARALYSIS:

The Committee has furnished every doctor in the state with a special pamphlet on cancer published by the American Cancer Society.

The National Foundation for Infantile Paralysis furnished a number of excellent leaflets to the Committee which were enclosed with other material sent to all persons on the mailing list. One of these articles was entitled, "When Polio Strikes, Helpful Hints for Everyone," and the second, "What Can the Schools Do About Infantile Paralysis."

MISCELLANEOUS:

The Committee assisted the Chicago Medical Society in furnishing publicity for their Annual Clinical Conference (later cancelled); prepared three different advertisements and furnished editorial matter on the Conference to twelve state medical journals and all county or city medical bulletins in those states.

Furnished outline of health material available in the state and catalog of publications by the A.M.A. to the Health Chairman of the Illinois Federation of Women's Clubs. All local health chairmen of women's clubs are now on the mailing list of the Educational Committee.

Material was collected and edited for the Illinois Medical Journal each month and was published under War Service Activities, News of the State and Death Notices.

Assisted the Chairman of the Medical Economics Committee in furnishing material to the members of

his committee and in mimeographing articles for their approval.

Suggested special programs and gave assistance to the Woman's Auxiliary.

Furnished material on health education to the Chicago Council of Social Agencies.

AID TO COUNTY MEDICAL SOCIETIES:

A new list of scientific speakers and subjects for county medical society programs was prepared in the fall and sent to all officers.

The Scientific Service and Post-Graduate Committee reports give in detail that part of the work carried on in the office of the Educational Committee.

The office of the Educational Committee mailed about 9,000 each of the pamphlets on Heart Disease, Endocrinology and Ophthalmology to all doctors of Illinois, all hospitals in the state, and all medical libraries and medical schools in the United States.

1,686 Notices were prepared and mailed announcing meetings of county medical societies.

300 Announcements of the Post-Graduate course in obstetrics at the University of Illinois College of Medicine were mimeographed and sent to obstetricians in the state.

597 Releases were prepared and mailed to Illinois newspapers announcing special medical society programs.

DO YOU KNOW COLUMN:

12,750 Releases of "DO YOU KNOW" to Illinois newspapers.

84 Special health columns to newspapers.

14,400 Copies furnished industrial physicians.

1,479 Copies sent to industrial house organs.

145,290 Copies sent to health chairmen, home bureaus, farm advisers, nurses, libraries, hospitals, etc.

14,154 Copies sent to school teachers.

55 Articles written on the following topics:

Hope for the Diabetic; Allergy—1 and 2; Child Health Day; Meningitis; Should Tonsils Be Removed; Heartburn; Sense and Sun; Don't Fool with Poison Ivy; Some Medical Symbols; Friends to Man; Who's Afraid; Periodic Health Examinations; Mental Illness; Pneumonia; Plantar Warts; Hazards of Swimming; Migraine; Venereal Disease Control; Cancer Is Not Seasonal; Nasal Medication; Scurvy; Scratches; Pure Water; Your Feet in Summer; How About a Vacation; War on Mosquitoes; Fire Prevention; Control of TB in Wartime; Rheumatic Fever; Varicose Veins; Are You Catching Cold?; Why Do Feet Hurt?; Wrinkles and Twinkles; Eat Your Pork Well Done; Time for Canning; Infantile Paralysis; Roentgen Rays; Back Pain; Get Rid of Rats; Respect Cancer; Mumps Are Trump; Doctors On Call; An American Custom; Scarlet Fever; Ear Troubles; Feeling Tired?; Gall Stones; Malaria Mosquitoes; What Is My Outlook? (TB); Bacteria and Cold Weather Infections; Your Crowning Glory; Fractures; Knee Action Troubles; Whooping Cough and May First.

SUMMARY

The Activities of the Committee were planned and arranged so as to disseminate a symmetrical and well balanced program of health information comparable to the fragments of colored glass in the kaleidoscope which are so arranged that changes of position exhibit its contents to an endless variety of symmetrical varicolored forms.

The program would not be possible without the excellent cooperation of members of the medical profession in all sections of Illinois.

Respectfully submitted,
R. R. FERGUSON, M.D.,
Chairman.
JAMES H. HUTTON, M.D.,
Vice Chairman.
ROBERT S. BERGHOFF, M.D.,
CHARLES P. BLAIR, M.D.,
C. PAUL WHITE, M.D.,
JEAN McARTHUR,
Secretary,
Educational Committee.

REPORT OF THE SCIENTIFIC SERVICE COMMITTEE

To The Members of The House of Delegates:

The War, with its curtailments of all descriptions particularly travel by train and automobile, has with one stroke had two effects. In the first place it has to a degree limited or decreased the primary objective of servicing our county medical societies with scientific programs. However, as the statistical data herewith given, will show, that decrease has been quite negligible. Our county societies have requested and have been supplied with speakers and without too much difficulty.

This is a tribute it seems to me to both speakers who in stressing times such as these, could and did take time out of their busy lives to travel to distant points to deliver their message and a tribute to the rank and file of our profession who sacrificed the time and long arduous trips to attend these meetings.

Your Scientific Service Committee tried wherever possible to send speakers to scientific meetings from a radius not exceeding fifty miles, thereby obviating long over-night journeys.

Programs were arranged for the following counties on the subjects listed:

Champaign	Greene
Kankakee	Bureau
Central District Medical Assn. of Iowa and Illinois,	
Kane	Williamson
Franklin	Adams
DeKalb	Henry
Stephenson	Randolph
Macoupin	Winnebago
Madison	Jefferson-Hamilton
Rock Island	Livingston
McLean	Logan
LaSalle	Macon
Will-Grundy	Vermilion
Coles-Cumberland	Mercer
Clinton	Morgan
Marion	

SUBJECTS:

Surgical Aspects of Acute Intestinal Obstruction.
Neuropsychiatry.
Appendicitis in Children.
Varicose Veins.
Surgery of the Large Bowel.
Progress in Ophthalmology.
Infantile Paralysis.
Pre-Operative and Post-Operative Care.
Lower Back Pain.
Therapeutics.
Tuberculosis.
Care of Wounds.
Anesthesia.
Diseases of the Blood.
Use of Sulpha Drugs and Penicillin.
Diseases of the Newborn.
Diabetes.
Obstetrics and Gynecology.
Heart Disease.
Surgery of the Biliary Tract.
Meningitis.
Head Injuries.
Fractures.
The Comon Cold Problem.
Urology.
Allergy.
Gastric Ulcers.
Rheumatic Fever.
Socialized Medicine and Prepayment Plans.
Convulsions in Children.
The Rectum as a Focus of Infection.
Carcinoma.
Arthritis.
Pneumonia.
Chemotherapy.
Industrial Medicine and Surgery.
Arteriosclerosis.
Syphilis.
Brain and Spinal Cord Injuries.
Dermatology.
Plastic Surgery.
Chest Diseases.
Immunization.
Mental Problems of the Aged.
Endocrinology.
Tropical Diseases.
Migraine.

The War with its entanglements has emphasized one more very important point, the necessity and demand for the service of this Committee NOW while the War continues and the rapid expansion of this service post-war when our professional brethren return.

Post-war planning is a universal theme, on everybody's mind and lips and nowhere does it apply more aptly and with greater force than in the work of this Scientific Service Committee. When our doctors come back to civilian life, they will expect and will be entitled to a resume of the scientific aspects of civilian medicine during their absence and the latest information on the newer things.

Accordingly your Scientific Service Committee does herewith recommend to the House of Delegates:

1. An expression of deep appreciation to the medical profession of Illinois both in our larger cities and teaching centers and also throughout the 101 counties scattered over the state for their local cooperation.

2. Gratitude to Jean McArthur and her associates for their invaluable assistance.

3. Not only a continuance of the service of the Scientific Service Committee, but its rapid and adequate expansion when this war is over to meet the needs and demands of our returned medical veterans.

Respectfully submitted,

Scientific Service Committee,
ROBERT S. BERGHOFF, M.D.,
Chairman.
JAMES H. HUTTON, M.D.,
J. S. TEMPLETON, M.D.,
F. H. FALLS, M.D.,
WALTER STEVENSON, M.D.,
HARLAN ENGLISH, M.D.,
HAROLD M. CAMP, M.D.,

REPORT OF THE POST-GRADUATE COMMITTEE

To The Members of The House of Delegates:

In our annual report to the House of Delegates last year, your Committee recommended approval to conduct four postgraduate conferences this year and secured that approval. When these conferences were first instituted five years ago, they were held more frequently as follows:

In 1940—Four one-day conferences were held, in Jacksonville, Champaign, DuQuoin, Dixon.

In 1941—Nine one-day conferences held in LaSalle, Decatur, Bloomington, Mattoon, Alton, Carbondale, Joliet, Freeport, Galesburg.

In 1942—Ten afternoon and evening conferences held in Councilor Districts.

In 1943—Four afternoon and evening conferences held in centrally located cities of the state.

In 1944—Four afternoon and evening conferences held in Bloomington, Rock Island, Centralia, Danville.

In this current year conferences were arranged and held at Decatur and Rockford on October 26th and November 15. Programs were also arranged for the doctors of Western Illinois at the Mayo General Hospital, Galesburg, on May 17, and Mt. Vernon for doctors of Southern Illinois in June.

The following programs have been presented—

DECATUR:

"Recognition and Management of Coronary Disease" —O. P. J. Falk of St. Louis.
"Industrial Surgery"—Frederick W. Slobe.
"Present Day Treatment of Syphilis of the Central Nervous System"—Clarence A. Naymann.
"Amebiasis"—Major Paul L. Shallenberger, Gardiner General Hospital, Chicago.
Round Tables—
"Diagnosis and Treatment of Heart Conditions

Occurring After Middle Life"—M. E. Rose, Decatur.

"Industrial Surgery"—Dwight Pence, Decatur.

"Child Behavior Problems"—Scott Wilkinson, Decatur.

"Tropical Diseases"—O. O. Stanley, Decatur.

"Neuropsychiatric Problems and the War"—Lt. Col. W. P. Richardson, Gardiner General Hospital, Chicago.

ROCKFORD:

Joint Luncheon with Rockford Lions Club—Mr. John W. Neal speaking on Socialized Medicine.

"Anesthetic Emergencies"—W. H. Cassels, Chicago.

Heart Clinic with Demonstration of Patients—Robert S. Berghoff, Chicago.

"Management of Rheumatic Fever"—Henry G. Poncher, Chicago.

"Penicillin, Its Practical Applications"—Lt. Col. O. W. Sicks, Gardiner General Hospital, Chicago.

"Use and Abuse of Sulfa Drugs"—Lt. Col. Earl R. Denny, Gardiner General Hospital, Chicago.

These postgraduate conferences are both important and popular and their number has been reduced simply because of the exigencies of war.

Your Postgraduate Committee recommends their continuance in the present stream-lined manner, but requests that they be expanded rapidly in number and scope as soon as practical after the war.

The Postgraduate Committee during this last year has sent to all doctors of the state, copies of three excellent pamphlets—Heart Disease, Endocrinology, and Ophthalmology. From comments received from not only doctors of Illinois but from many other states, it is evident that this type of postgraduate education has a place in our general program of bringing the latest in medicine to every practicing physician. A fourth booklet on Dermatology will be sent during the late summer.

Respectfully submitted,

Postgraduate Committee,

ROBERT S. BERGHOFF, M.D.
Chairman.

R. R. FERGUSON, M.D.,
CHARLES P. BLAIR, M.D.,
FRANK DENEEN, M.D.,
WALTER STEVENSON, M.D.,
C. O. LANE, M.D.

REPORT OF THE COMMITTEE ON MATERNAL WELFARE

To The Members of The House of Delegates:

On presenting the eighth annual report of the Committee on Maternal Welfare of the Illinois State Medical Society, we wish to remind you that we have been greatly handicapped in carrying out our program the past year, due to the induction of a large number of our leading medical men into the armed forces of our country. Notwithstanding this great handicap, our work has continued with a reasonable degree of success, as shown in a recent report from the Department of Public Health at Springfield, showing the Maternal Mortality of Illinois has been reduced to the new low of 1.08 per thousand births.

Much time has been given by this Committee, in cooperation with the Department of Public Health, in securing better working conditions of the federal service men's obstetrical set-up for Illinois.

The Committee has met three times this year. The first meeting, in July, was held in Quincy, Illinois, where the members were guests of Doctor Milton E. Bitter. A very interesting and instructive program was given, and Doctor Bitter was voted a most genial host. The other two meetings were held at the Palmer House in Chicago, the time being devoted to the Maternal Welfare and Federal Maternity programs.

The following program was approved for the guidance of the county chairmen throughout the State:

1. More emphasis should be placed on adequate prenatal care;

(a) Monthly visits up to the seventh month then every two weeks—history, physical examination including pelvic measurements, weight and dietary instructions. Laboratory work consisting of urinalysis, Kahn, blood count including red, white and hemoglobin, should be done, preferably on the first visit.

2. We recommend that each County Medical Society should appoint a Maternal and Child Welfare Committee whose duties should consist of:

(a) Investigate maternal, fetal and early infant deaths for constructive study in reducing mortality. Post-mortems on neonatal deaths should be encouraged. This investigation to be carried out by the County Chairmen and other physicians appointed by local medical society; all information pertaining to this study to be kept in the hands of the medical profession.

(b) Have an adequate number of programs on maternal welfare and pediatric subjects before local society and hospital groups to meet the need of that community.

(c) Encourage the educational program among the nurses of the community by such means as moving picture and special lectures and special invitations should be rendered to attend obstetrical and pediatric programs before medical groups.

(d) Encourage any improvement of local hospital facilities for better maternal care.

3. We suggest that the chairman of the Maternal Welfare Committee be designated as the County Chairman and be responsible for the furthering of this program in his respective county with the cooperation of the local medical society.

We suggest that he appoint a permanent Maternal Welfare Committee composed of the professional and lay groups to further the program of lay education.

4. Encourage post-graduate work and refresher courses among the physicians.

5. We recommend consultation in all obstetrical complications.

6. Encourage programs on Maternal Welfare before hospital staff.

7. We recommend that physicians stress the danger of abortions.

8. Avoid indiscriminate use of oxytoxic drugs, especially in first and second stage.

We recommend that every effort be put forward to maintain the Maternal Welfare program in Illinois in the hands of the State Medical Committee.

We further recommend that the folders, "Advice to Expectant Mothers" and "Abortions", prepared by this committee be furnished by the State Society, when requested, to all practicing physicians.

Respectfully submitted,

Maternal Welfare Committee

T. B. WILLIAMSON, M.D.,
Chairman.

JOHN F. CAREY, M.D.,
Secretary.

A. B. OWEN, M.D.,
J. T. O'NEIL, M.D.,
F. H. FALLS, M.D.,
WORLING R. YOUNG, M.D.,
R. LYNN IJAMS, M.D.,
R. E. BUCHER, M.D.,
MILTON E. BITTER, M.D.,
LEE O. FRECH, M.D.,
W. C. SCRIVNER, M.D.

REPORT OF THE COMMITTEE TO STUDY PREPAYMENT PLANS FOR HOSPITAL AND MEDICAL CARE

To The Members of The House of Delegates:

Your Committee begs to make the following report in reference to its study of prepayment plans for hospital and medical care.

The Commitee was appointed in keeping with the action of the House of Delegates of the Illinois State Medical Society in May, 1944. At its first session Dr. Rollo K. Packard introduced the following resolution in reference to prepayment plans for hospital and medical care:

> Whereas, there is a growing tendency on the part of the public for prepayment plans for hospital and medical care, and
>
> Whereas, the American Medical Association has approved group hospitalization plans and cash indemnities for medical fees, and
>
> Whereas, there is a growing demand among subscribers for hospital care that medical indemnity be included, and
>
> Whereas, group hospitalization plans throughout the country are studying the feasibility of such cash indemnities subject to approval of state and county medical societies,
>
> Therefore be it Resolved, that the House of Delegates of the Illinois State Medical Society approve the plan in principle and the Chairman of The Council appoint a committee to cooperate with the hospital service plans in Illinois in developing a program for the inclusion of voluntary medical indemnity benefits and this Committee report to the Council of the State Society as soon as feasible and carry out such instructions as the Council may authorize for the consummation of this plan.

This resolution was referred to the Resolutions Committee for its consideration and recommendations. It was considered by the House of Delegates at its second meeting on May 18, 1944, at which time the Resolutions Committee made its report. The resolution was discussed by different members of the House. Although the original motion considered only the question of cooperating with hospitalization plans, the discussion brought out the desirability of the proposed committee studying all types of prepayment plans for medical care, including those written by insurance companies. Dr. Packard, who introduced the resolution, concurred in the recommendation of the discussants that the study include all types of prepayment plans for medical care. The resolution was adopted empowering the Chairman of the Council to appoint a special committee to study and survey all types of prepayment plans for hospital and medical care.

In an effort to bring into the Committee a representative cross section of the membership of our Society, members were appointed representing the various fields of medicine and surgery in metropolitan and rural areas, industrial medicine, specialized fields of medicine and general practice.

In the study of this problem the Committee made a special study of all the prepayment plans for medical, surgical and hospital care in the United States, giving special consideration to Blue Cross Plans as well as the different Hospital Plans in the State of Illinois.

We devoted one entire day's conference to interviews with the medical representatives of the following neighboring states: Michigan, Indiana, Missouri, Iowa and Wisconsin. We carefully inquired into what they had done in reference to prepayment plans for medical, surgical and hospital care, the different types of plans in operation in their states, those in the process of formation, likewise their experience in reference to these plans and also regarding enabling legislation concerning prepayment plans.

We interviewed employers representing large and small industrial organizations, numerous railroad representatives, many insurance carriers, agricultural organizations, representatives of hospitals and charitable institutions. We likewise interviewed representatives of Blue Cross Plans as well as other group hospital plans and medical plans in the State of Illinois.

It is to be noted that there are different types of prepayment medical plans, among which are the medical service plan and the cash indemnity plan.

Medical service plan is a prepayment plan under the complete control of the medical profession. In this type of plan payment for medical service is made directly to the attending physician at a definite predetermined rate for service.

The cash indemnity plans differ in that a specified payment is made directly to the patient by the Plan,

this money to be used by the patient toward the payment of professional services.

Hospital prepayment plans provide daily hospital expenses, such as bed, board and nursing, and special hospital charges exclusive of medical care. Some Hospital Plans operate as a cash indemnity to the patient. Others operate as a service plan with payments made to the hospital.

In the course of our study the Committee found that while the majority of medical service plans operated pursuant to enabling legislation, in some states no such procedure was deemed necessary.

The Committee has also very carefully evaluated the trend of national legislation in regard to socialized medicine. There is beyond a question of doubt a demand for such plans by the citizens of this nation.

The Committee is greatly impressed as are most physicians and medical organizations with the great strides that have been made in organizing prepayment plans throughout the nation since the last meeting of the House of Delegates of the Illinois State Medical Society in 1944. In that interim the majority of State Medical Societies have made a very careful study of this problem. Many have adopted some type of prepayment plan for medical and surgical care. Others have introduced enabling acts preparatory to such activities. It is the opinion of your Committee that the House of Delegates of the Illinois State Medical Society should give very special consideration to the question of adopting some type of prepayment plan for medical care during its meeting in 1945.

It is the Committee's information that the Medical Service and Public Relations Commitee of the Illinois State Medical Society has given very careful consideration to the need for an enabling act to cover this type of service in the state of Illinois. We are also informed that such legislation has been introduced in the present session of our State Legislature.

The Committee would like to state that it noted a desire and a tendency of Blue Cross Hospitalization Plans to expand so as to include prepayment plans for medical care. The advisability of such expansion was questioned by your Committee due to the control of most hospital service plans being outside that of the medical profession.

The Committee believes that the rapid changes that are taking place throughout the nation in reference to this problem demand its further consideration and evaluation. It is the Committee's intention to continue this study and to present to each of the members of the House of Delegates a more detailed supplementary report prior to the meeting of the House of Delgates. The Committee urges each of you to give very careful consideration to the study of this problem, familiarizing yourselves with the different types of plans and their operations and troubles. The Committee would refer you to the articles that are appearing in the current journals so that each member of the House will be familiar with this very important subject.

The question of whether to adopt a statewide plan in Illinois and what type of plan it should be, if any, is a problem for the members of the House of Delegates of the Illinois State Medical Society to decide. It is the opinion of your Committee that very serious consideration should be given to the question of adopting a cash indemnity plan.

Respectfully submitted,

Committee to Study Prepayment Plans for Hospital and Medical Care,

CHARLES H. PHIFER, M.D., *Chairman.*
EDWIN S. HAMILTON, M.D.,
FRANK DENEEN, M.D.,
ROBERT KEETON, M.D.,
RICHARD J. BENNETT, M.D.,
JOSEPH H. CHIVERS, M.D.,
CHARLES P. BLAIR, M.D.,
ROBERT S. BERGHOFF, M.D.,
JOHN W. NEAL,
EVERETT P. COLEMAN, M.D., *Ex Officio,*
HAROLD M. CAMP, M.D., *Ex Officio,*
PERCY E. HOPKINS, M.D., *Ex Officio.*

REPORT OF THE COMMITTEE ON THE MEDICAL CARE OF PUBLIC ASSISTANCE RECIPIENTS

To The Members of The House of Delegates:

Your Committee desires to submit the following report in reference to the medical care of old age assistance, aid to dependent children, blind, and relief, each recipients of public assistance in the State of Illinois.

While the Illinois Public Aid Commission is the administrating agency for the entire program in the State of Illinois, the fact that over one-third of the beneficiaries reside in the County of Cook and that their supervision and administration is invested in that County in two different local governmental agencies, each operating separate programs, financed differently, but both assisted by the Illinois Public Aid Commission, makes it necessary to make this report in two parts. Part I, all the counties in the State of Illinois except the County of Cook (101 counties); Part II, County of Cook.

GENERAL STATEMENTS

Your State Committee has met at regular intervals with representatives of the Illinois Public Aid since the last meeting of the House of Delegates. It appears to the Committee that much has been accomplished in simplifying and coordinating the operation of this program since the time it was first created. There have been provisions made for the payment of final illness. The amount of paper work has been greatly reduced. There exists better understanding and knowledge of the program by the local administrators and the medical profession. The County Medical Advisory Committees are assisting in the program. There is also a much better working relationship between the local representatives of the administrative agency, the members

of the medical profession, and the local governmental units.

Physicians throughout the state have frequently asked if legal complications might arise through the physicians releasing the diagnosis of the disease of the recipients to the administrating agency from which they are receiving assistance. The Attorney General of the State of Illinois was asked for his opinion by the Illinois Public Aid, and the Illinois State Medical Society's Advisory Committee sought legal counsel from the representatives of the Medical Society. Each of these authorities has rendered an opinion that no liability was involved in releasing the diagnosis.

In the early part of this program your Committee had many complaints about the state because of inability of physicians to collect their medical services in final illness. The 63rd General Assembly passed an appropriation for $850,000 for the next biennium to help provide funds for payment of medical and hospital services and the last illness of the recipient. The Committee was then asked by the Illinois Public Aid Commission to set up a definition of what should constitute the time to be included in final illness. Inasmuch as our Program was then in its beginning we recommended that any illness prior to sixty days of the death of the patient be construed as that of final illness. During the past year the Medical Advisory Committee and the Illinois Public Aid have extended this time to any medical service rendered within six months that was associated with the cause of death.

In the care of old age recipients the program is finding several problems that present trouble, namely, that they may be acutely or chronically ill, senile, or they may suffer such ailments that they may not be able to meet their physical needs. In the event that they do not have friends or relatives they must be placed in an institution where this care can be provided. The low and limited grant that they receive does not provide for extensive accommodations. Many of them require continuous nursing care. It is not the general policy of most hospitals to admit the aged who are not acutely ill. The nursing homes in the State vary in type and kind. The great majority of them give very poor service. They are all operated for profit. The lack of proper standards and licensing of homes complicate the medical care of the chronically ill in this group. Efforts are being made by the administrative agency to secure the enactment of legislation in this state to help regulate and standardize these institutions. Homes of this type should not only help the physicians in giving better medical care to the chronically ill among the public assistance recipients, but they will also help the medical profession in the care of chronically ill that are not recipients. They would also make more beds available for the acutely ill in other classes of patients in our hospitals.

While the problem of relief in this state at this time is not as large as in the past, it does constitute a problem. The Commission and your Committee has continued to encourage the free choice of physicians in planning general relief programs. A few local relief programs provide only contract physicians' services. In some counties even though the contract physicians provide medical care to the local governmental units, other physicians may sometimes be used. In one county in the state the combined efforts of your Medical Advisory Committee, local and state, the Commission's district representative, the Councilor of the State Medical Society, the County Relief Administrator now provides that the recipient may either consult the county physician or the physician of his choice. This is a pattern to be emulated by other counties which provide contract practice.

In this connection your Committee called the attention of the members of the House of Delegates in 1944 to the fact that in certain local governmental units the medical care of the recipients was being provided through contract practice. It was the opinion of your Medical Advisory Committee that this did not provide good medical care, that it was contrary to the principles of American medicine as well as other programs of this type each of which provides for the free choice of physician by the patient. The Reference Committee to which this report was assigned concurred in the matter and referred the problem to the Council of the Illinois State Medical Society, requesting that the individual Councilors try to have this type of medical care discontinued in their Councilor Districts. The fact that many physicians are in military service made this a difficult task. It is, however, the hope of your Committee and the Council that it may be accomplished before the next meeting of the House of Delegates.

The Sub-Committee on Ophthalmology consisting of Drs. Harry Gradle, Chairman, Walter D. Stevenson, Watson Gailey, and Charles H. Phifer, ex officio, have given much time and careful consideration to the many problems in connection with the question of conservation of vision in this program. During 1944 the Sub-Committee continued to meet with the Commission to consider problems connected with certain aspects of the blind assistance program, such as those in determining visual eligibility and arranging for corrective surgery for recipients of blind assistance. They also reviewed the question of the definition of blindness and revised the definition which became effective March 15, 1945, which reads as follows:

> In terms of ophthalmic measurements central visual acuity of 20/200 or less in the better eye with correcting glasses is generally considered economic blindness. A field defect which reduces the visual field efficiency to 30 percent may be considered equally disabling, as may certain handicapping ocular conditions which are not related to visual acuity or peripheral field limitations which do limit visual function.

In connection with the revised definition of blindness examination reports were revised and because the number of eye examinations now required to determine visual eligibility has decreased, the list of examining ophthalmologists was reduced in accordance with the recommendations by the Sub-Committee.

It is also to be noted that during the past few years the Commission and the State Medical Advisory Committee have been faced with the problem of determining the need for and the cost of radiation therapy for recipients of public assistance. The problem in the opinion of your Medical Advisory Committee required consideration by men skilled in the field of radiation. In keeping with that the Medical Advisory Committee appointed a Sub-Committee in 1944. This consisted of Drs. Roswell Pettit, Chairman, Fred Decker and Warren Furey, Charles H. Phifer *ex officio*. This Committee was charged with the duty of studying the question of fees to be recommended to the Illinois Public Aid in the treatment of malignancies among these recipients under the Social Security Law. This Committee sent out questionnaires throughout the state to men specializing in this field, collected data and have made recommendations in reference to charges for radiation therapy, either superficial or deep. These fees are now being studied and it is the hope of your Committee that they will soon be available for the use of the Illinois Public Aid Commission and the Medical Advisory Committee.

There are 1455 local governmental units in the State. The number that receive State funds varies according to the need for funds and likewise their eligibility. The definition of eligibility in this connection is as follows: Any governmental unit charged with the duty of providing relief and support for all the poor and indigent persons lawfully resident therein which has failed to levy within the time that such levy is authorized to be made, at least 3 mills of each dollar of the total equalized value of all taxable property therein for such purpose." In January, 1944, there were 155 units receiving State funds for relief purposes. In January, 1945, the number of units was 115.

CASE OPENINGS: There were 2375 relief cases opened in January, 1945, an increase over the number in December, 1944. Need for medical care and hospitalization accounted for 45.8 of the total openings; loss of employment 26 per cent; miscellaneous causes responsible for the balance.

The members of the Medical Advisory Committee are frequently asked questions by members of the medical profession as to why certain people have been enrolled as participants in one of these categories. This problem is not associated with our part of the program. We, however, think the following data might be informative:

It is the responsibility of each state's administrative agency (I. P. A. C. in Illinois) to determine whether a person making application to become a beneficiary under the Social Security Program comes within the rules and regulations governing the category in which he is applying for assistance.

We attach herewith a statement relative to the income of recipients. Approximately 71 per cent of recipients are solely dependent upon their assistance payments for support. The remaining 29 per cent have other income in cash or kind. This figure excludes earnings from agriculture, labor performed by the recipient, since the Old Age Pension law provides that income from this source shall be exempt from consideration. Approximately 19 per cent of all recipients have an income in cash averaging $9.09. The average amount and source of cash is shown in the table below:

Source	*%*	*Average Payments*
No cash income	81.4	$00.00
Cash income	81.6	9.09
Old age survivors	1.7	15.74
Allotment and allowances for members of the armed forces	.3	17.59
Earnings of recipients	3.6	6.23
Contributions from relatives	7.1	9.76
Other sources	5.9	6.96
Total	100.00	1.69

Contrary to the general opinion the Social Security Law does not require citizenship as a condition of eligibility for public assistance. The Social Security Act permits the states to require citizenships as a condition of eligibility for public assistance. Illinois requires citizenship for old age assistance but not for A. D. C. or the blind. It is the opinion of the Illinois Public Aid, however, that old age assistance should be given to non-citizens if they are needy or eligible.

PHYSICAL CONDITION OF OLD AGE: In a recent study of the physical condition of the recipients of old age in this state the majority were able to care for themselves. Three per cent were confined to bed because of illness or infirmity, 13 per cent were not bedridden but required considerable care due to chronic illness, 84 per cent were able to care for themselves. Eighty-four per cent of recipients living in nursing homes were either bed-ridden or required considerable care from others.

MEDICAL CARE: The medical needs of almost one out of five recipients (19 per cent) included some amounts for medical care. The table here shows the amount for medical care included in the budget:

Amount	*Percentage*
$ 1 to $ 2	18%
3 to 9	66%
10 to 19	12%
20 to 29	2%
30 and over	2%

Under the medical care program that became effective January 1, 1945 grants may be supplemented from state funds as high as $75.00 in case medical care cannot be met within the $40.00 government payment plan over a period of twelve months. *THIS DOES NOT APPLY IN THE COUNTY OF COOK.*

The number of recipients benefitted from the public assistance programs began a downward trend in February, 1942. They continued downward through December, 1944. The number of old age recipients began the largest decrease in this program during March, April, May and June, 1944. It was at this time that the effects of the free investigation of chil-

dren who were responsible for their parents was most evident. The trend of old age pensions grants has been steadily upward from the beginning of the program to December, 1944. No definite trend in the blind assistance program has been evident in the past few years. In January the increase in general relief assistance ended the uninterrupted downward trend which began in 1942.

DECEMBER, 1944

	Total	*Downstate*	*Cook*
General Relief	56,228	25,422	30,806
Old Age	124,004	79,483	44,521
A. D. C.	46,669	25,775	20,894
Blind	5,233	3,305	1,928
Total	232,134	133,985	98,150

Some duplications.

We attach in this report a map showing the percent of population benefitted from the four major public assistance programs in Illinois for 1944 based on the 1940 census. This map gives you the counties with their notation as to the distribution of these programs. There are also two other charts, one a comparison of case load, 1944-45, and the other, a supplementation of funds.

There has been considerable agitation during the past few years among the administrating agencies to try to simplify and codify the laws governing these programs in the State of Illinois so as to avoid duplication of activities. The following legislation has been contemplated in this session of our Legislature:

1. Remove state requirements for citizenship as a qualification for old age pension.
2. Provide adequate grants for aid to dependent children (which has required supplementation up to date).
3. Adjust Chicago's six million dollar annual peg levy for relief so that the state will assume more of the relief cost.
4. Uniform the various state welfare laws to prevent confusion.
5. Increase the maximum of 10 per cent total relief costs now allowed for administrative expense. (It is stated that the 10 per cent is adequate to operate on when the load is heavy but when the relief load falls it does not provide adequate personnel of caliber needed to give sufficient administration).

CASE LOAD COMPARISON

Program	*Total*	101 *Downstate Counties*	*Cook County*
Old Age Pension			
January 1944	141,937	92,222	49,715
January 1945	123,521	79,195	44,326
Blind Assistance			
January 1944	6,154a	4,380a	1,774
January 1945	5,238	3,305	1,933
Aid to Dependent Children			
January 1944	53,778	28,720	25,058
January 1945	46,984	26,034	20,950
General Relief			
January 1944	73,931	35,597	38,334
January 1945	56,898	26,235	30,663
Total Persons on Assistance			
January 1944	260,793b	157,240	103,553
January 1945	220,922c	131,901	89,021

a Includes 1,437 receiving aid from county program.
b Excludes duplications of 15,007 children receiving aid to Dependent Children Supplementation.
c Excludes duplications of 11,719 persons receiving Supplementation to Old Age Pension, Aid to Dependent Children, and Blind Assistance grants.

SUPPLEMENTATION OF OLD AGE PENSION AND BLIND ASSISTANCE CASES

Month	*Old Age Pension*	*Blind Assistance*
January (1944)	$ —	$ —
February	32,480.48	956.79
March	30,420.44	813.35
April	34,600.65	951.19
May	31,008.05	1,009.79
June	31,353.73	785.13
July	35,086.97	1,046.82
August	37,909.16	872.35
September	32,298.23	1,282.79
October	33,561.74	914.73
November	37,132.15	1,051.72
December	36,832.15	1,177.76

COUNTY OF COOK—CHICAGO RELIEF

This Is The Report of The Chicago Advisory Committee of The Chicago Medical Society on The Medical Care of The Indigent Within the Corporate Limits of Chicago.

The program has been well organized and operating continuously since March, 1933. There has been excellent cooperation between the Chicago Welfare Administration and the Medical Profession of Chicago since this program was organized. It is to be noted that in the beginning the case load was so heavy that at the time it required a meeting of the Medical Advisory Committee with representatives of the C. W. A. every week in order to dispose of the medical agenda. For the past few years we met every two weeks. The meetings were then lengthened to once a month.

The relief case load had continued to decline until in December 1944 it was 30,806.

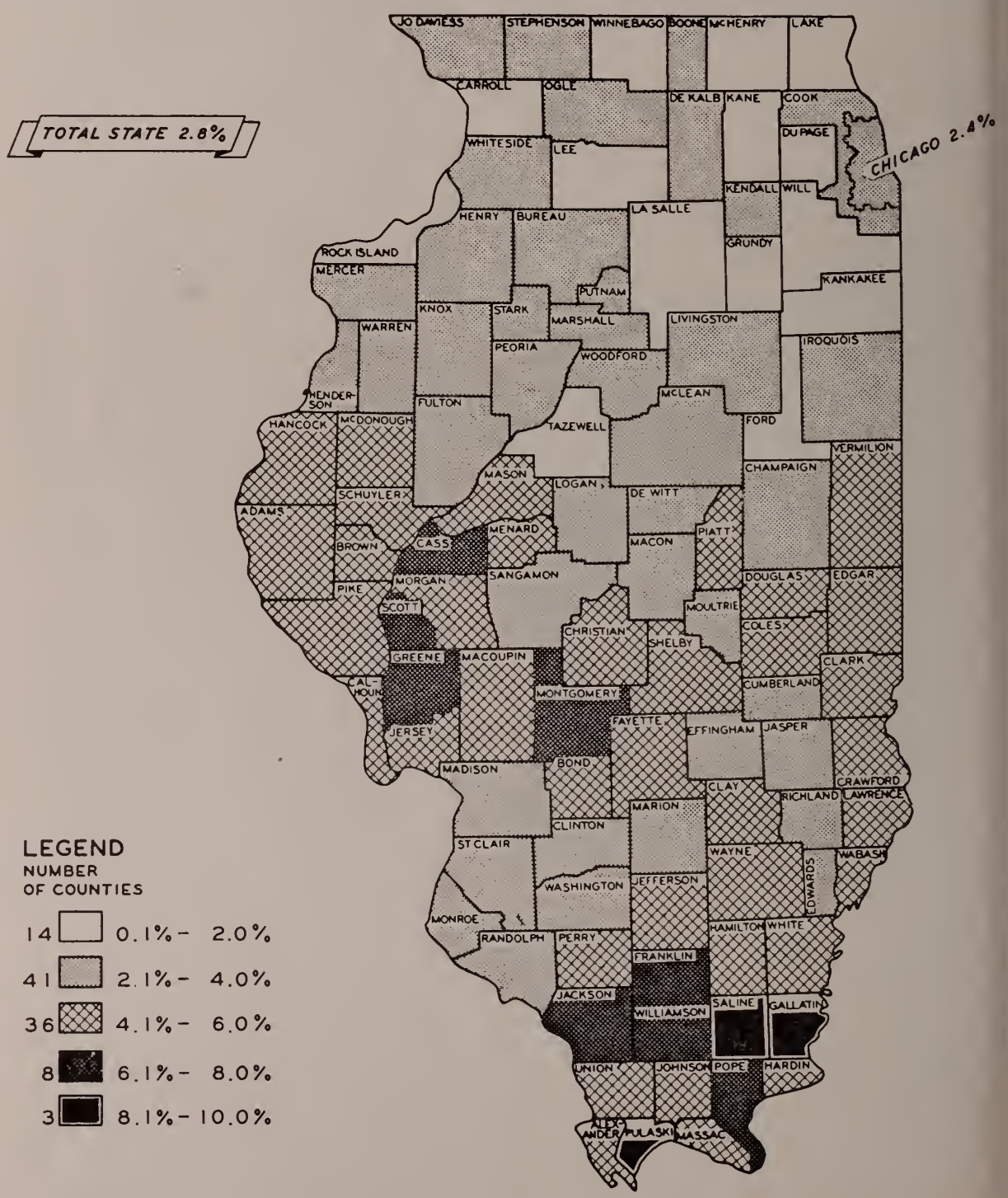
AID TO DEPENDENT CHILDREN: The number of these cases which required supplementation during 1944 decreased from 5,019 in 1943 to 3,639 on December 1, 1944.

The type of persons requiring relief assistance has changed in recent years as evidenced in December 1944. In the early part of this picture we had families of four, five and six. At present the families are reduced to one or two persons.

During the past year we noted that the A. D. C. cases which required supplementation represented 22 per cent of the total case load. These persons, how-

PER CENT OF POPULATION BENEFITING FROM THE FOUR MAJOR PUBLIC AID PROGRAMS IN ILLINOIS DECEMBER 1944

(BASED ON 1940 CENSUS)



ever, comprised 44 per cent of the total relief persons, indicative of the type of people constituting a large percentage of present relief rolls.

EMPLOYMENTS: The cooperation of the Chicago Welfare Administration and the Advisory Committee of the Chicago Medical Society represents what can be done with civic organizations in helping to reduce the number of people on relief. The fact that the Chicago Welfare Administration has maintained a medical unit where these recipients could be repeatedly examined as to their physical condition was constructive. This made it easier for the Chicago Welfare Association to find employment for those able to work. The Chicago Welfare Administration also set up a placement service, the object of which was to find employment for people on relief rolls who were not physically capacitated to do all kinds of work but could find suitable limited employment, thereby making it possible for the recipient to earn some income.

In 1944 the placement service aided 3,253 persons in private employment. This is somewhat less than in 1943 when they placed over 8,000 persons. The fact that many of these recipients had a limited degree of employability made this a difficult task. The lower the case load dropped the greater the number of people in it that were unemployable or capable of taking very limited employment. It is to be noted that on October 31, 1944, only six and one-half per cent of all the relief load were employable and most of them were of limited types only.

We enclose herewith a memorandum on the obligations of medical care by type contracted during 1944 and 1943 by the Chicago Welfare Administration.

Type of Care	1944	1943
Total	$624,618.92	$699,112.77
Clinic Care	115,762.20	167,779.25
Dental Care	51,121.14	50,041.54
Hospital Care	214,909.62	170,786.90
Medical Appliances	12,557.94	20,246.86
Convalescent Care	109,085.15	121,167.32
Physicians' Fees	57,193.50	91,915.00
Home Nursing Care	12,716.52	15,396.00
Drugs	24,148.02	39,886.03
Miscellaneous Items	27,124.83	21,893.87

PHYSICIANS' SERVICE: The fact that many physicians have entered our military service has reduced the number of physicians on the roster. During the twelve months period in 1944 there were 1,331 doctors on the roster serving the relief recipients. Of this number there were about 256 each month who rendered medical service. The total amount paid to physicians during 1944 was $57,193.50. There were 28,552 home visits made and 1133 office visits. It is to be noted that from the time this program began in 1933 to December 1, 1944 there were 1,065,883 home visits made, 27,739 office visits, 2,578 obstetrical cases. The average number of physicians participating each year is 1,252.

PAYMENTS TO COOK COUNTY HOSPITAL AND OAK FOREST: The fact that the present statute of the State of Illinois places the responsibility of the overseer of the poor on the Administrator of Relief of the city of Chicago, the only institutions in which these patients were cared for have been Cook County Hospital and Oak Forest. During 1944, $120,242.00 was paid to the Cook County Hospital for 26,755 patient days as compared to $94,665.00 for 19,445 days in private hospitals. The Chicago Welfare Administration paid during 1944, $298,245.55 for care of relief patients in Oak Forest.

CONVALESCENT AND CHRONIC CARE: During 1944, the Chicago Welfare Administration saw the need of changing its policies in regard to its convalescent homes to make provisions to handle their recipients who were being discharged from Cook County Hospital but were unable to go home and needed chronic medical care. The policy for admittance of chronic care patients to the convalescent home was referred back to the Medical Advisory Committee for recommendations concerning these admissions. The recommendations included admittance for those relief patients in Cook County Hospital who no longer needed hospital care but needed convalescent care before being discharged. It is gratifying to note that many of the long term cases have responded to treatment in some instances have regained considerable function. It is a definite policy of the convalescent home to assist every patient from his bed each day if such patient is not acutely ill. This home was opened in 1935. All types of patients have been admitted, including some who have regained their health and become self-supporting to those whose remaining days are few and who will never be able to leave the home again.

It should be noted that the change in the legislation which made it mandatory upon the Chicago Welfare Association to pay Cook County for the paupers in Cook County Hospital, also changed the relationship between the County and the Welfare Association regarding non-paupers needing convalescent care outside their own homes.

The Committee greatly appreciates the cooperation and assistance that we have had from Mr. G. J. Klupar, Commissioner of the Chicago Welfare Administration, Miss Alice Saar, Director of the Medical Division, and her assistants. This relationship has been very constructive and has added much to the medical care of these recipients as well as the conservation of funds. It likewise demonstrates what constructive cooperation can do in programs of this type.

Respectfully submitted,

CHARLES H. PHIFER, M.D.,
Chairman,

JOSEPH CHIVERS, M.D.,
FRED H. MULLER, M.D.,
WARREN FUREY, M.D.,
JULIUS H. HESS, M.D.,
JAMES H. HUTTON, M.D.,
HAROLD W. MILLER, M.D.

COOK COUNTY

The Report of the Chicago Medical Society's Advisory Committee to the Cook County Bureau of Public Welfare.

The Committee desires to report that the Illinois Public Aid Commission's program for the medical care of the old age assistance, the aid to dependent children and the blind has had considerable difficulty in its operation in the County of Cook during the past year. We would like to call your attention that when legislation was enacted by the General Assembly of the State of Illinois making provision for the payment of final illness, the Cook County Bureau of Public Welfare made no payment for final illness either in the corporate limits of the city of Chicago nor the town of Cicero. It was for that reason that the Medical Advisory Committee discontinued its meetings with the Cook County Bureau of Public Welfare in October, 1943. There were several meetings held and it was not until February 14, 1944 that an agreement was finally reached between the Cook County Bureau of Public Welfare and the Public Aid Commission so that arrangements were set up in these two governmental units for the payment of medical care in final illness. The latter being established, meetings of the Medical Advisory Committee with representatives of the Cook County Department of Public Welfare were re-established and continued to meet regularly to discuss problems connected with the medical care of these recipients. The number of people on these rolls has been reduced somewhat over that of a year ago by reason of more careful investigation regarding applicants' children being able to support their parents; secondly, the employment of a number of these people in war industries. The function of this Committee continued through 1944. The agendas were long, the medical problems were many, and much time was required in reviewing medical records and passing on policies. These categories in the County of Cook included old age, 44,521; A. D. C., 20,-894; blind, 1,928. This number of recipients in one county necessarily increased the burden of the Medical Advisory Committee. The program then proceeded without interruption until January 1, 1945 when Illinois Public Aid's new program went into effect regarding the supplementation of state funds to pay for medical services and hospital care. The new program had been announced stating that the Commission would increase monthly payments up to $40.00 when needed for hospital care or physician's fees. When the cost of either or both could not be met in this way the Commission would provide additional funds by raising the grant to $75.00 to pay for physician's fees, drugs, and hospital bills. That any cost of medical care for the last illness which could not be met because of the death of the recipient would be met by the Commission. The Commission stated that this new program would make it possible for old age pension and blind assistance recipients to obtain adequate medical care without having to apply to two different agencies.

This program as announced by the Illinois Public Aid looked constructive. It did not, however, state that the program would apply to all the counties in the state except the County of Cook, that in the County of Cook recipients would be subject to a different type of a program, namely, that if the recipient were sick at home he might have the free choice of a physician, but if his illness required hospitalization he would be restricted to the use of hospitals that would furnish him hospitalization, room, board and medical care for five dollars a day, that he would not have in that instance the free choice of physicians or hospitals. The Cook County Medical Advisory Committee objected to the program as it was to operate in the County of Cook. They held two meetings with the representatives of the Illinois Public Aid Commission and the Chicago members of the Illinois Hospital Association. They presented their problem to this group asking that the recipients in the County of Cook should receive the same consideration that they did in the rest of the state, and the physicians in the County of Cook be paid for their services the same as they were in the remainder of the state. The Committee later met to discuss this problem, after which they wrote to the Illinois Public Aid Commission calling their attention to the restrictions on the operation of the program in the County of Cook, first, that it discriminated between the recipients in the County of Cook and those down state in that it deprived them of free choice of physicians as well as hospitals; secondly, that it discriminated between the physicians in the County of Cook and those down state; thirdly, that it lowered the status of the recipient in the County of Cook from that of a non-pauper to that of a pauper; fourth, that the decision regarding this policy of medical care was passed upon by the Illinois Hospital Association and the Council of Social Agencies, two non-medical groups; fifth, that it established contract practice of medicine by corporations.

It was the opinion of the Committee that their function as a Medical Advisory Committee had been assumed by two non-medical groups, that inasmuch as the objective for which the Medical Advisory Committee had been appointed to the Cook County Bureau of Public Welfare had been assumed by other organizations, the Committee could therefore see no further use for its acitvities. They asked the Council of the Chicago Medical Society to accept the resignation of this Committee and not to appoint a new Committee. They also asked the Council to notify the Illinois Public Aid Commission that the Chicago Medical Society had always been pleased to cooperate in providing medical care for low income groups if and when they had the free choice of physicians, that regardless of the fact that the schedule of fees to these recipients was of low remuneration the profession was happy to cooperate in trying to provide medical care for them, that it seemed apparent that the Illinois Public Aid Commission was seeking the guidance of non-medical people to assist in this program. There has been an attempt on the part of the Illinois Public Aid

Commission to reestablish this medical program in the County of Cook through the Chicago Medical Society. It is to be noted that at the time this report goes to press such has not been accomplished. The Council of the Chicago Medical Society believes that these recipients in the County of Cook as well as the physicians in the County of Cook are entitled to the same consideration that is given to those in the remainder of the state.

Respectfully submitted,

Committee on Medical Care of Public Assistance Recipients,

CHARLES H. PHIFER, M.D., *Chairman*
HARRY M. HEDGE, M.D.,
F. LEE STONE, M.D.,
LUCIUS COLE, M.D.,
FRED H. MULLER, M.D.,
WARREN FUREY, M.D.,
JULIUS H. HESS, M.D.

CONCLUSIONS

It is the opinion of your Committee that the program is working well in all the counties of the state except the County of Cook. We believe that there has been a steady improvement in this program since it began. This is the first time in the history of this program that the County of Cook has had a controversy. It is not a dissention over the fees allowed for visits or medical services but a question of a difference of opinion regarding the policy adopted by the Administering Agency in this County.

Your Committee desires to state that report of the Illinois Public Aid Commission's publicity statement relative to the proposed change in the medical program as of January 1, 1945 was approved by your Medical Advisory Commitee is slightly in error. The Committee's opinion was sought relative to the proposed program effective January 1, of raising the grant as high as $75.00 in case the cost of medical and hospital bills could not be met within the regular $40.00 grant in a period of twelve months. The Committee thought this suggestion constructive and sanctioned it. It was not, however, until after the program went into effect that the Medical Advisory Committee was informed that the program could not be operated in the County of Cook, that instead of the same type of program that was operated down state, it was the intention of the Illinois Public Aid Commission to give the recipient in the County of Cook the free choice of physician if he were ill at home, but that if and when hospitalization was needed he would be restricted to the use of a hospital which would provide hospitalization, board, room, nursing and medical care for five dollars per day, that he would then be treated as a service case by the Medical Staff. We are informed that the new decision with reference to the medical care of recipients in the County of Cook was made on the advice of members of the Hospital Committee representing the Illinois Hospital Association and representatives of the Council of Social Agencies. We are certain that neither the members of the Medical Adivsory Committee or members of the medical profession have ever sanctioned this type of medical care. It would seem that the decision was made on an economic basis rather than on the type of medical care the recipient would receive. We believe the ruling to be an error of judgment of the Illinois Public Aid Commission based on the advice they received from non-medical people. The Committee sincerely hopes that in the interest of the health and welfare of the recipients of the Illinois Public Aid Commission as an administering agency it will try to correct its recent decision. It is our opinion that the pattern of the program for the care of these recipients should be the same throughout the State of Illinois. In support of this it is evident that the grants these people receive throughout the state are all provided under the Social Security Law and the Illinois enabling act. The Legislature of the State of Illinois provided the money that is being used for supplementary grants for medical care of these recipients. It does seem unfair to the members of your Medical Advisory Committee that organizations would try to reduce the status of these recipients from that of non-paupers to paupers under the proposed program. The Committee has gone on record as requesting that the same privilege be extended to physicians and recipients in the County of Cook as are extended down state.

Your Committee desires to express its kind appreciation to the members of the medical profession in the State of Illinois, the County Medical Advisory Committees, the members of the Illinois Public Aid Commission, Mr. Raymond Hilliard, Director of Public Aid, Miss Pearl Bierman, Medical Consultant, and Miss Marjorie Bates, Assistant Consultant, for their assistance in this program.

Respectfully submitted,

CHARLES H. PHIFER, M.D.,
Chairman
EDWIN S. HAMILTON, M.D.,
JULIUS H. HESS, M.D.,
JAMES H. HUTTON, M.D.,
EVERETT P. COLEMAN, M.D.,
Ex Officio.
HAROLD M. CAMP, M.D.,
Ex Officio.
PERCY E. HOPKINS, M.D.,
Ex Officio.

REPORT OF THE COMMITTE ON TUBERCULOSIS

To The Members of The House of Delegates:

While your committee has had no formal meetings or formulated any definite program during the past year, it has kept in touch with all important phases of tuberculosis control in the State. Information has been obtained and studied bearing on all the major problems as presented from time to time and the committee has followed the trends of procedure used by the various organizations dealing with tuberculosis as they might affect the physician and related health agencies, both lay and official.

The control of tuberculosis is well covered by the Illinois Department of Health through its Division of Tuberculosis Control, the Illinois Tuberculosis Association and its component county association, the various city and county sanitarium districts, the district health officers and the city health departments. A close cooperative link has been established between these bodies which gives Illinois one of the outstanding tuberculosis control programs in the country, as a whole. There are some areas notably in the south portion of the State, however, and the northwesterly regions which at present do not have adequate facilities for the care of tuberculosis patients, but there is at present legislation contemplated which would meet this need by erection of state sanatoria, three in southern Illinois and one in northwestern Illinois. The situation in Cook County is a problem that also must be solved, probably by erecting several sanatoria, but this matter has been left to a special Cook County Committee to work out.

The Division of Tuberculosis Control lost the services of Dr. Steinkoff, who was its first Director and who left the division to take the position as director of a sanatorium, but this loss was met by the appointment of Dr. Clifton Hall of Big Rapids, Michigan, who came from the Division of Tuberculosis Control of the Kansas Health Department. Dr. Hall has already shown an aggressive and stimulating interest in his work and has grasped the problems of our State in a clear and certain manner.

Many of the County Medical Societies have not yet appointed Tuberculosis committees, but in those that have, such committees have aroused considerable interest among the Medical men of their community in the subject and by working with other tuberculosis control bodies in their county have formulated plans and carried out programs that are outstanding. Those counties that have not done so have missed a splendid opportunity for service and are urged to organize their committee at once. Any help that your Tuberculosis Committee can supply will be freely given to get programs started in each County Medical Society in Illinois. The ideal program for tuberculosis control must of course, enlist the services of the members of the local medical society, but there should be a close liaison between the various lay, professional and tax supported organizations, that deal with tuberculosis, so that a definite, logical and continuous program may be worked out, without loss of time, money or energy due to overlapping or conflicting programs. Such a cooperative program is being followed out by the several counties, one of which, the Peoria Medical Society, has a committee to work with the other cooperative organizations so that at the present a comprehensive program is given the county and city for the control of tuberculosis.

The Illinois Tuberculosis Association is working closely with the Division of Tuberculosis Control and the Standardization Committee of that organization is serving as the advisory committee to the Division of Tuberculosis Control. The four State Sanitarium project mentioned above is one of the products of this team-work and other programs are now in the process of formulation.

Bills have been introduced in the legislature to provide a fund of $4,000,000 to provide sanitarium care in the State, sponsored by this commitee and Gov. Green which would grant $1.50 per day for each patient hospitalized in the State. The only funds provided by the State heretofore has been the $20,000 appropriated for the Division of Tuberculosis Control. Other states have tuberculosis control funds reaching millions of dollars with State Sanitaria and clinics to provide tuberculosis control service, but Illinois has never had such a fund.

Such a plan will be especially necessary in the future when the postwar tuberculosis problem becomes more urgent and to provide care for returned service men. The American Legion has already planned for the future of the tuberculous veteran and will work with other tuberculosis agencies to call the attention of the veterans to the need for detecting and treating tuberculosis cases after the war.

Rehabilitation and properly planned work for tuberculosis cases is another problem that must be recognized by Medical Societies and cooperating bodies and your committee will keep informed on this phase of tuberculosis control and care, so that the post-sanitarium patient will secure work suitable for his physical condition and yet allow the community to have the benefit of the result of labor he may be able to do.

Your committee requests communications or questions from any county association that needs assistance and will endeavor to supply information, speakers or other material available.

Respectfully submitted,

Committee on Tuberculosis Control,

FRANK J. SMEJKAL, M.D.,
Chairman.

FRED M. MEIXNER, M.D.,
HERMON H. COLE, M.D.

REPORT OF COMMITTEE ON MEDICAL ECONOMICS

To The Members of The House of Delegates:

The Medical Economics Committee was organized during the latter part of 1944 and early 1945. The roster of membership is as follows:

Chauncey C. Maher, Chairman, 6 North Michigan Avenue, Chicago,

Harry A. Oberhelman, 310 South Michigan, Chicago,

Edwin S. Hamilton, Kankakee,

V. Thomas Austin, 602 W. University Ave., Urbana,

Emmet B. Bay, 950 East 59th St., Chicago 37,

Jay McDonald Milligan, 164 Division St., Elgin,

George Halperin, 535 N. Dearborn St., Chicago 10,

Marie Wessels, 720 N. Michigan Ave., Chicago 11,

Thomas C. Browning, 2136 Indiana Ave., Chicago 16,

Roland R. Cross, Director State Dept. Public Health, Springfield,

Milton E. Bitter, Quincy,

Edwin F. Hirsch, 1439 S. Michigan Ave., Chicago 5,
Ford Hick, Lt. Col. MC, Mayo General Hospital, Galesburg,
William J. Bryan, Rockford,
John R. Vonachen, Peoria.

The Committee has published two articles in the Journal of the State Society, the first an announcement of membership and proposed activities, and a second on the Beveridge Report. A third article is in press at the moment, concerning the Murray-Wagner-Dingell Bill.

Three other articles are now ready for publication concerning the "Selection of Medical Students," and "Medical Education." The third is a study of the County Poor Farms of Illinois.

Other editorials are in the process of preparation on subjects concerned with the various plans which have been developed throughout the United States concerned with prepayment insurance for medical care. Other subjects include studies on the status of general, specialty and clinic practice in the state, resident and post-graduate training and other phases of our medical economy.

Up to date, the committee has carried on its activities solely by correspondence, due to the exigencies of war. The first formal conference was set for May 9th in Chicago. At that time, the committee clearly defined its responsibilities and scope of activities.

In general, the fundamental aim of the committee is to fully acquaint the members of the Society with the problems of our medical economy and solutions which are being offered from many sources.

The committee will also consider at its next meeting, ways and means of more fully acquainting medical students with the problems of medical economics, a subject which occupies a rather unimportant place in their present medical school curriculum.

The committee wishes to formally acknowledge the consistent aid of Dr. Harold Camp, editor of the Journal, and Miss Jean McArthur.

Respectfully submitted,

Committee on Medical Economics,

CHAUNCEY C. MAHER, M.D.,
Chairman,

HARRY A. OBERHELMAN, M.D.,
EDWIN S. HAMILTON, M.D.,
V. THOMAS AUSTIN, M.D.,
EMMET B. BAY, M.D.,
JAY DONALD MILLIGAN, M.D.,
GEORGE HAPERIN, M.D.,
MARIE WESSELS, M.D.,
THOMAS C. BROWNING, M.D.,
ROLAND R. CROSS, M.D.,
MILTON E. BITTER, M.D.,
EDWIN F. HIRSCH, M.D.,
FORD HICK, M.D., Lt. Col. MC,
WILLIAM J. BRYAN, M.D.,
JOHN R. VONACHEN, M.D.

REPORT OF THE COMMITTE ON ETHICAL RELATIONS

To The Members of The House of Delegates:

The work of the Ethical Relations Committee has been very light the past year. The Edgar County-Dr. Churukian Case is still on its agenda. Final action has been delayed by the misplacing of some of the pertinent papers. As soon as these are either found or replaced the Committee will again review the case hoping to get a final settlement.

The Hall Case was referred to the Committee for its consideration. No action was taken in this case, as none was requested and the entire case was handled locally. Unfortunately there was some publicity from the outside, and pressure was applied for action by the State Society, but in the opinion of your Committee this was wholly a County Society problem.

During the year, the serious illness of Dr. R. K. Packard made the appointment of Dr. G. Henry Mundt necessary in his stead. We are pleased to learn that Dr. Packard has recovered and has returned to practice.

Respectfully submitted,

EDWIN S. HAMILTON, M.D.,
Chairmar

CHARLES H. PHIFER, M.D.,
G. HENRY MUNDT, M.D.

REPORT OF THE COMMITTEF ON WAR PARTICIPATION

To The Members of The House of Delegates:

Your War Participation Committee has not been called upon to perform much specific work the past year. It has cooperated with various other Committees of the Society, especially the Committee on Procurement and Assignment, whenever any problem of cooperation between the medical profession and the war effort has arisen. Fortunately Illinois has been able to fill its quota of physicians throughout the entire war, and while the major credit for this must go to the Committee on Procurement and Assignment some small portion should go to this Committee.

With the end of the European War and partial demobilization of the armed forces, many problems involving the medical profession and the continuing war effort are bound to arise and it is quite possible that this committee will be called on considerably more to assist in demobilization of the medical profession and the work of getting them properly distributed throughout the state. Most of the members of the Committee are conversant with the problems of the medical profession in this regard and should be able to be of valuable assistance, when and if the same is requested.

Respectfully submitted,

EDWIN S. HAMILTON, M.D.,
Chairman,

H. M. HEDGE, M.D.,
E. H. WELD, M.D.,
PERCY E. HOPKINS, M.D.,
G. HENRY MUNDT, M.D.,
HAROLD M. CAMP, M.D.

REPORT OF THE COMMITTEE ON CANCER

To The Members of The House of Delegates:

Your committee is pleased to submit the following report of its activities for the year 1944-1945, and proposes specific recommendations. As has been the case in past years the chief function of this committee has been in the capacity of an advisory board on matters concerning cancer control to all agencies and organizations throughout the state. It has been gratifying to note the spirit in which its advice has been sought and accepted. This attitude bespeaks the confidence the public has in organized medicine. The committee feels that such an attitude will continue so long as organized medicine will place the welfare of the public before that of its own members and let no selfish motives interfere. There exists at the present time a wholesome cooperative spirit between the committee and all organizations concerned with cancer control and it is quite obvious that such a spirit will continue providing the medical profession will keep step with the times and make every effort to provide for the scientific professional demands as expressed by the mass of the intelligent public and not be unduly influenced by social reformers or misinformed zealots.

ADVISORY COMMITTEE TO THE DIVISION OF CANCER CONTROL, DEPARTMENT OF PUBLIC HEALTH OF THE STATE OF ILLINOIS. This committee consisting of prominent physicians under the leadership of Dr. R. T. Pettit of Ottawa has been active throughout the year. The chairman has devoted a great deal of time to matters concerning the committee, visiting institutions both within and without the state. He has been constantly in close contact with the Department of Public Health and its director. In January the entire committee met with the officials of the Department of Public Health in Springfield. Your committee was extremely gratified by the spirit displayed by the officials of the Department of Public Health and the willingness of the department to cooperate not only with the medical profession but with other agencies concerned with cancer control.

Three Tumor Diagnostic Services established down state are functioning satisfactorily. The one in Peoria is no longer receiving a subsidy from the State because of unsatisfactory conduction. The Department of Public Health has been consulted by representatives of several other districts with the proposal that diagnostic services be inaugurated. These proposals are now under consideration. It must be stressed again that the medical profession throughout the state should utilize these facilities more freely. If the medical man does not avail himself of the scientific help in the diagnosis and treatment of cancer, then the public will demand the privilege of seeking such aid and counsel independent of the family physician. Such a step would be deplorable. The Department of Public Health has subsidized within limits the tumor clinic at the Illinois Research Hospital in Chicago.

The Advisory Committee is investigating Bill Number 191 just introduced into the State Legislature relative to the construction of a State Cancer Hospital. The officials of the Department of Public Health are extremely anxious to be advised relative to this project and have expressed a desire to follow the advice and counsel of the advisory committee. This bill is the outcropping of a popular demand for specific and skilled care of the cancer patient and reflects to a degree a failure of the medical profession to meet the requirements in the minds of many responsible citizens. Such projects must be considered very seriously by the profession and especially by the House of Delegates. A memorandum has been sent by your chairman to the House of Delegates through the secretary of State Society relative to this project. The implication of this bill is far reaching and is not limited to the provision of a cancer hospital. It signifies a definite trend. This trend has been recognized for the past few years and has been alluded to very specifically in the annual reports of this committee. This committee requests instructions from the Council or the House of Delegates of the State Society as to its attitude and what position your committee should assume. If there is any question in the minds of the members of the House of Delegates or the Council, the committee respectfully requests that it be called into conference. The committee considers this a serious matter but one that can be satisfactorily adjusted providing the medical profession does not veer too far to the right.

THE CHICAGO CANCER COMMITTEE, INC. This organization is continuing in the capacity of a coordinating agent for the Chicago area. During the past year the chairman, Dr. Ludvig Hektoen, resigned and Dr. George E. Wakerlin, Professor of Physiology of the University of Illinois, was elected chairman. Dr. Herbert E. Schmitz, Dr. Danely P. Slaughter and Mrs. Ralph W. Webster were added to the board of directors. A number of forums were given during the year including, by invitation, the one on "Facts About Cancer," before invited guests of the Illinois Athletic Club on April 16, and the Chicago Chapter, American Banking Institute, on March 13. All forums have been quite well attended.

The affiliation of the Cancer Committee, Inc. with the Tuberculosis Institute of Chicago and Cook County during the past year was satisfactory and it is contemplated to renew the affiliation for the ensuing year. The Cancer Committee has entered into an agreement with the Field Army of the American Cancer Society to occupy joint offices at 139 North Clark Street, Chicago. Plans are being studied to form an information center to be conducted jointly with the Field Army. In the past the Field Army has been conducting such a center at its offices at 48 West Division Street, Chicago. The Chicago Cancer Committee, Inc., plans to increase its scope of activity during the coming year in cooperation with the broader plans of the American Cancer Society.

AMERICAN CANCER SOCIETY, FIELD ARMY. In January of 1945 it was announced that changes had been made in the framework of the American Society for the Control of Cancer and the name was changed to The American Cancer Society and Field Army. At the time of this writing a National drive is being conducted in an effort to procure $5,000,000.00 for contemplated activities of the American Cancer Society. This drive is under the National chairmanship of Eric Johnston, president of the United States Chamber of Commerce. In brief, it is the intention of the Society to obtain a large sum of money to be devoted to a well coordinated research program, this being under the jurisdiction of a committee of nationally known cancer research workers. An educational quota of approximately $80,000.00 has been allocated for Illinois. Of this amount 75 per cent remains in Illinois for local work and 25 per cent goes to the National offices. Of the 25 per cent that goes to the National office 15 per cent is to be placed into the research pool. An overall quotation of $560,000.00 has been set for Illinois. Of the amount over the $80,000 educational quota, 50 per cent remains in Illinois for local work and 50 per cent goes to the National office for the research pool. The plans for Illinois are now being developed with the assistance of a lay and professional committee under the chairmanship of Mr. Charles Glore of Chicago. Your chairman has asked for an enlargement of the Cancer Committee of the State Society to include three physicians from down state so they may function on the Executive Committee of the Field Army.

The Field Army is under the able direction of Mrs. Arthur I. Edison who is devoting an unbelievable amount of time and effort to the work of the organization. The chief projects of the Field Army at present are lay and student education, surgical dressings units and the Cancer Prevention Clinic at the Women's and Children's Hospital in Chicago. The plans for student education are progressing favorably and it is hoped that very soon the fundamental and basic principles of cancer can be presented to students in high schools and junior colleges. When this has been accomplished a far reaching step will have been made toward preparing the coming generation for cancer control in its widest interpretation, moreover, the student will carry information into his family thereby educating parents and other adult relatives. The department of Public Health of the State of Illinois has been very cooperative and has provided for the Field Army a large amount of printed literature for general distribution.

The Cancer Prevention Clinic is now in operation two evenings each week. The demand is so great that the clinic is booked many months in advance. The work of the clinic is well described in an article by Dr. Augusta Webster and her staff in the March number of the Journal of the Illinois State Medical Socicty. A large amount of material is becoming available for study and it is contemplated that other articles will appear from time to time. There is no question but that extremely valuable information will be assembled within the next few years. The clinic has met with general approval of the medical profession since it is not in competition with the practitioner. No cases are treated, all being sent to the family physician for care. The clinic may be considered as an experiment in cancer control and should in the end prove or disprove the value of periodic examinations for the detection of early cancer. It is entirely possible that the findings in this clinic may provide the basis for our future medical conduct in the detection of early cancer. This clinic deserves the approval and confidence of the medical profession. Your committee can vouch for the honesty and self-effacing attitude of the staff of the clinic. These women merit praise and not criticism. Because of the great popularity of the clinic the public is demanding more such clinics. This problem is now receiving much attention, not only by your Committee on Cancer but by other cancer control organizations such as the advisory committee to the Division of Cancer Control, Department of Public Health of the State of Illinois. At the present it seems that to a considerable extent the division will depend upon the physicians themselves. If physicians will meet the demands of their patients for an adequate examination the largest percentage of patients will go to their family physicians for such an examination. If the physicians will not prepare themselves to provide adequate examinations for their patients then the patient will demand it from other sources and in the end will obtain services through government or social facilities operating without the consent of the organized medical profession.

In the report of this committee to the House of Delegates made in May 1944 the following admonition was included: "Your committee is definitely of the opinion that cancer control has gained a very definite foothold and that it will be one of the foremost programs before the public in the coming years. * * There is no question but that social service agencies recognize this fact and are ready to step in and institute their programs unless the medical profession handle the situation efficiently. Likewise unless the medical profession exerts itself to provide adequate diagnostic and therapeutic facilities, the people will demand it from the State."

Much of this prophecy has already become a reality. The Advisory Committee to the Division of Cancer Control, Department of Public Health was informed by the Director of Public Health in January 1945 that the State Legislature was much concerned about the cancer problem in Illinois and virtually demanded an answer from the medical profession. The inference was strong that if the medical profession did not propose a solution then the legislature would take action. Bills introduced in the present Illinois General Assembly indicate that decisive action by the medical profession must be taken at once. The medical profession can no longer sit idly by and oppose projects and offer nothing constructive in lieu. Unless we act now, act with a spirit of the public welfare at heart

and with the help of and cooperation with prominent lay citizens, the organized medical profession can no longer control the destiny of medical practice in Illinois.

Your committee on cancer therefore requests that a special committee be selected consisting of prominent physicians throughout the State, men who will give freely of their time in an effort to find a solution to the cancer problem that is satisfactory not only to the medical profession but to the lay population. It is suggested that this committee be built around the cancer committee since the personnel of this committee is familiar with the problems concerned. Permission should be given to this committee to add to its personnel from without as well as within the medical profession. Also the committee should be intrusted with the authority to make commitments within limits for the State Medical Society in an effort to find and perfect a mutually agreeable solution. In detail the duties of the committee would be: 1. To study the problem of cancer control in Illinois. 2. To formulate a comprehensive plan for such control that will meet with the approval of the medical profession and the public. 3. Suggest ways and means to put plan into operation. 4. To make a report with recommendations to the Council of the State Medical Society or to the House of Delegates as soon as possible. (Attention must be called to the fact that no delay in action is possible. The extensive publicity given to cancer by the American Cancer Society during its April drive for funds will make the public demand specific action without delay.) The expenses of the committee should be paid by the Illinois State Medical Society.

Your committee wishes to thank the House of Delegates for its interest in the work of the Cancer Committee, the officers of the Society and the Council for their cooperation and courtesy, being ever-ready to assist the committee in its work and to Miss McArthur and the Educational Committee for their sincere and gratuitous assistance. The chairman wishes to express his thanks and appreciation personally to the individual members of the committee for their willing help and cooperation.

Respectfully submitted,
Committee on Cancer,
JOHN A. WOLFER, M.D.,
Chairman,
BOWMAN C. CROWELL, M.D.,
ANDY HALL, M.D.,
ROSWELL T. PETTIT, M.D.,
JAMES P. SIMONDS, M.D.,
J. J. MOORE, M.D.,
HARRY OTTEN, M.D.,
C. L. LEONARD, M.D.

REPORT OF THE COMMITTEE ON INDUSTRIAL HEALTH

To The Members of The House of Delegates:

During the past year, the organization of industrial health committees in the twenty industrialized counties in Illinois has been gradually extended. Although several industrial health conferences were held in different parts of the State, the number of such meetings has not been all that might be desired. However, it is realized that because of the shortage of physicians, it has been difficult for many of the county societies to hold such meetings and for the county industrial health committees to materially augment their activities. It is believed that when the scarcity of physicians becomes less acute, these activities will be facilitated in their expansion.

The Industrial Health Section of the "Illinois Medical Journal" has been continued each month, consisting of abstracts, articles, and informative data relative to industrial health. It is hoped that this section has been of interest to readers of the Journal.

An interesting recent Chicago development is the planning toward the establishment of a Rehabilitation Center Project. While this is not essentially industrial in scope, it does have important industrial implications and your committee wishes every success to the project which is under the chairmanship of Dr. Carl Peterson. Similar Centers are successfully operating in other cities and it is felt that Chicago should have the same opportunity. This has been endorsed in principle by the Chicago Medical Society.

Another development which is pending in Chicago and on which considerable developmental work has been done is a health education program in industry which may be named, "The Industrial Health Committee of Chicago", patterned after the Fort Greene Project in Brooklyn, New York, which has been in reasonably successful operation for about a year and a half. This was originally sponsored by the Chicago Medical Society, the Council of Social Agencies of Chicago and the Chicago Health Department with cooperating agencies such as the Educational Committee of the Illinois State Medical Society, the Industrial Hygiene Division of the State Department of Public Health, the Chicago Society of Industrial Medicine and Surgery, the Chicago Dental Society, the Industrial Nurses' Section of the Illinois State Nurses' Association, the Cook County Public Health Unit, the Municipal Tuberculosis Sanitarium, the Chicago Tuberculosis Institute, the Illinois Society for the Prevention of Blindness, and Labor groups represented by the C. I. O. and A. F. L. Most of these groups have given official approval and expressed their desire to cooperate, and similar approval has been given by the Committee on Industrial Health of the American Medical Association. Many preliminary meetings have been held with representatives of these groups and also with representatives of the Illinois Manufacturers' Association and the Chicago Chamber of Commerce. It is realized that progress in a development of this kind will be slow as it is aimed at one of the most difficult problems in industry, namely, health education in the small plant.

Your committee has also had representation on the Committee of the Chicago Medical Society appointed to investigate medical service plans. It has also met with representatives of insurance companies and

lawyers relative to complaints against some physicians as to their testimony in public liability cases and before the Industrial Commission. After preliminary discussions, this latter matter was referred to the appropriate committee of the Chicago Medical Society for disposition.

Members of your committee have participated in industrial health conferences both in Illinois and in adjacent states and also in connection with some programs presented by the Postgraduate Committee of the State Medical Society. Joint meetings held by the Chicago Society of Industrial Medicine and Surgery with other special societies such as the Heart, Gynecological and Urological Societies have been helpful in developing the industrial application of these specialties. The Central States Society of Industrial Medicine and Surgery held a joint meeting with the Illinois Medical Society in 1944.

Your committee deeply appreciates the help and encouragement of the officers of the Illinois State Medical Society, the members of the Council and the House of Delegates, the editor of the Illinois Medical Journal, the Council and officers of the Chicago Medical Society and its Branches, the officers and the Industrial Health Committees of the various county medical societies, the Division of Industrial Hygiene of the Department of Public Health, the American Association of Industrial Physicians and Surgeons, and of the Council on Industrial Health of the American Medical Association.

Respectfully submitted,
Committee on Industrial Health,
FREDERICK W. SLOBE, M.D.,
Chairman.
F. P. HAMMOND, M.D.,
HAROLD VONACHEN, M.D.,
C. O. SAPPINGTON, M.D.,
MILTON H. KRONENBERG, M.D.

REPORT OF THE COMMITTEE ON VENEREAL DISEASE CONTROL

To The Members of The House of Delegates:

The Committee on Venereal Disease Control has been very active during the past year, as the new Director, Dr. G. G. Taylor has contacted the members on many occasions. As you will note from Dr. Taylor's summary which is part of this report, venereal diseases have presented a real problem. This has been occasioned by the stepped-up War Program with its transient employees in the defense areas, and the laxity of the enforcing agency. Dr. Taylor should be commended for his efforts to focus the attention of the laity as well as the profession on venereal diseases by bringing to the District, Dr. Pelouze of Philadelphia. He was well received and his address received favorable comment of the local press as well as all of the interested groups who heard him. The attached report of Dr. Taylor shows the tremendous effort being made by the Division of Venereal Disease Control, with the cooperation of the physicians of the State, to stamp out this menace by education of the public, intensive search for the infected individuals and adequate medical treatment.

Respectfully submitted,
Committee on Venereal Disease Control,
I. H. NEECE, M.D.,
Chairman.
B. C. CORBUS, M.D.,
HARLAN ENGLISH, M.D.

REPORT OF THE DIVISION OF VENEREAL DISEASE CONTROL, ILLINOIS HEALTH DEPARTMENT YEAR 1944

COOPERATION WITH THE SELECTIVE SERVICE SYSTEM

During 1944, there were 250,651 blood tests taken from Selective Service registrants—9,119 of these (3.64%) were positive.

The National Round-up of Selective Service Registrants infected with syphilis was instituted in the State of Illinois under the sponsorship of the United States Public Health Service. Tabulations of this round-up as of February 1944 for the entire State of Illinois exclusive of Chicago, showed that a total of 8,577 men were found to have positive blood tests or other evidence of syphilis at the time of their preliminary Selective Service examination. This group was subdivided into a total of 1,790 men who were 25 years of age or younger at the time of examination, 6,032 who were 26 years of age or older, and a mixed group with unclassified ages totalling 755 men. It was found that 25 per cent of the men found to have evidence of syphilis were already inducted or enlisted in the armed forces as of February 1944. About 19 per cent were available for induction, another 19 per cent probably would never be available for military service, due to the presence of syphilis in its late stages or other disqualifying factors, and approximately 18 per cent of the group still needed further treatment.

PREMARITAL BLOOD TESTS

In accordance with the Illinois premarital examination law, during 1944 there were 96,145 blood tests made, of which 3,066 were positive (3.19%).

PRENATAL BLOOD TESTS

In accordance with the Illinois prenatal examination law, during 1944 there were 79,855 tests made, of which 1,189 were positive (1.49%).

STATE LABORATORY EXAMINATIONS

During 1944 the following laboratory examinations were made by the Illinois Department of Public Health Laboratories and the Chicago Board of Health Laboratories:

A. Syphilis	
1. Blood tests	1,166,077
2. Spinal fluid examinations	9,200
3. Darkfield examinations	8,724
B. Gonorrhea	
1. Smears	239,775
2. Cultures	90,642

C. Chancroid Examinations 2,346
D. Granuloma Inguinale Examinations 147
E. Lymphogranuloma Examinations 1,725

REPORTING OF VENEREAL DISEASES

In 1944, 48,711 cases of venereal disease were reported in Illinois. These included 25,297 syphilis, 22,587 gonorrhea, 613 chancroid, 187 lymphogranuloma venereum and 27 granuloma inguinale cases. These cases were reported by private physicians, clinics, military establishments, State Hospitals, private hospitals and other institutions in Illinois.

TREATMENT PROVISIONS

Treatment facilities for the medical care of indigent infectious venereal disease cases are provided by venereal disease clinics, private hospitals, State Hospitals and private physicians.

A. Venereal Disease Clinics:

In 35 Downstate Illinois Clinics there was a monthly average case load of 3,938 syphilis patients for 1944.

B. Private Hospitals:

Thirteen private hospitals in Downstate Illinois have been utilized for the administration of a method of rapid treatment therapy of early infectious cases of syphilis and gonorrhea.

During 1944, 242 cases were cared for. These were hospitalized for 1,599 days at a cost of $8,650.39. The average cost of hospitalization per case was $35.75.

C. State Hospitals:

Five State Hospitals have been designated as quarantine hospitals for the isolation, treatment and diagnostic facilities for patients found infected or suspected of being infected with a venereal disease. Nine State Hospitals have been designated to hospitalize positive spinal fluid cases for fever therapy.

During 1944, 160 positive spinal fluid cases were hospitalized for fever therapy, and 470 cases were hospitalized for quarantine and treatment.

D. Private Physicians:

Treatment facilities have been provided for in those cities where no clinic has been established, as well as in sparsely populated areas too far distant from a venereal disease clinic or State institution, by paying private physicians $2.00 per treatment for the care of venereal disease cases referred to them.

There were 175 cases of syphilis and 85 cases of gonorrhea treated in this manner in 1944.

EPIDEMIOLOGY

The success of the control of syphilis and gonorrhea depends very largely upon the careful tracing of every infection to its original source and the investigation of every person whom the patient might have exposed.

The following table presents the results of 5,729 completed contact investigations made during 1944. These contacts were named on military contact referral forms, morbidity reports, other State referral forms, and correspondence for follow-up.

Analysis of Complete Investigations of Contacts (Name Given) 1944

	Number	*Percent*
Total Investigations	5,729	100.00
Examined, not infected	1,770	30.89
Found under treatment	342	5.97
Placed under treatment	937	16.35
Unable to locate	1,019	17.79
Moved out of jurisdiction	403	7.03
Inducted into Armed Forces	29	0.51
Patient uncooperative	98	1.71
Physician refuses permission	12	0.21
Other disposition	64	1.12
Information insufficient for investigation	1,055	18.42

REPORT OF THE COMMITTEE ON VETERANS' REHABILITATION

To The Members of The House of Delegates:

The Veterans' Rehabilitation Committee of the Illinois State Medical Society formulated several principles last year. This Committee had a few meetings at which these principles were put into definite form and plans were laid for the future care of returned Illinois veterans from World War No. II, who might have non-service-connected disabilities requiring treatment.

Dr. Hermon Cole of Springfield, Illinois, who is a member of this Committee, is also the liaison officer of the Illinois State Department of Public Health. He has the same function with respect to the American Legion and several other closely related organizations. As a result, he has represented this Committee at numerous meetings and has attended one meeting in Washington, D. C. The accomplishments of these meetings are rather considerable, and as it is his work almost alone in representing the Committee, his attached report really is the report of the Committee. It represents the excellent work of one of our most active and valuable members.

Respectfully submitted,
Committee on Veterans' Rehabilitation,
EVERETT P. COLEMAN, M.D.,
Chairman.
FRANK DENEEN, M.D.,
E. E. NYSTROM, M.D.,
E. W. MUELLER, M.D.

REPORT VETERANS' REHABILITATION COMMITTEE

The function of this Committee has been to formulate and, insofar as possible, to direct the principles of medical care of returning disabled veterans in the State of Illinois. As a result of several conferences held in Chicago and downstate early in 1943 and 1944, certain basic principles were agreed upon by the heads of the Illinois State Medical Society and Council, the Illinois State Department of Public Health, and the Medical Consultant of the Governor's Committee on Veterans' Rehabilitation and Employment. All action since that time has been directed toward seeing them

carried out. These principles, in general, were as follows:

1. The care of returning veterans, medically, in the locality to which they return.

2. Free choice of physician by the veteran with provision for the County Medical Society to name in rotation the physician to do the necessary work if the patient has no choice.

3. Hospitalization in locally situated hospital or in localities nearest to the veteran's home.

4. Medical aid only in cases unable to provide for their own care so as to interfere with private practice as little as possible.

5. Care to be paid for on an agreed fee basis out of funds provided by the State and National rehabilitation fund established for that purpose.

The Committee has at this time to report that set of principles has been rigidly adhered to throughout and that all of these are in force and effect in the State of Illinois, not only insofar as veterans are concerned but in the care of civilians who come under the Rehabilitation Act as well! In addition, a similar set of principles as regards dental care has been worked out with the Illinois State Dental Society and it is also in effect and operation at this time.

As to hospitalization, several conferences have been held with the various heads of the Hospital Association and with Catholic organizations at which time full cooperation has been attained. At this time hospital care is obtained by either of two plans as follows:

1. In participating hospitals, on the Children's Bureau plan or per diem rates, or

2. On a straight fee paid hospital service.

At this writing the two types of service are about equally divided as to their preference.

In connection with this work it is to be remembered that the service-connected disabilities of all veterans are a *federal* responsibility with which we have nothing to do except to see that the veteran is properly referred and actually gets to the Veterans' Facility for care. The method and instrumentality through which this Committee has brought this about has been as follows: One of our committee members, Cole, has been named by the Illinois State Department of Public Health (Dr. Roland Cross, Director) as liaison officer between the Department of Public Health, the Illinois State Medical Society representing the physicians of the state, and the Governor's Committee on Veterans' Rehabilitation and Employment. The liaison officer is acting as Medical Consultant to the Governor's Committee, Medical Consultant to the Department of Rehabilitation of the State of Illinois, State Medical Rehabilitation Officer of the American Legion and, finally, as vice chairman of the Governor's Medical Advisory Committee on Rehabilitation under Dr. Roland Cross who is chairman. These connections give the Illinois State Medical Society a very strong representation in all Rehabilitation Councils in Illinois. In addition, the Illinois State Medical Society Council is well represented on all advisory groups in the rehabilitation field. The vital importance of this is easily perceived if we as physicians are to exercise any measure of control over the scope and type of medical service to be provided our returning veterans.

In the near future a large number of servicemen and women reasonably may be expected to return to civilian life and an unknown number may be expected to have disabilities not regarded as service-connected which will have to be corrected before they can again be self-supporting and kept off of relief rolls. It is vitally important that the medical set-up to provide this service be continued under our control and in accordance with the principles laid down and now in operation. Should we lose this control, it would mean a federally operated service of immense proportions, and all of this service would be removed from the hands of the physicians in private practice in the State of Illinois! Should this happen, it is only a step to federal medicine for the soldiers' families and federalization of hospitalization as well. So far, our liaison officer reports excellent cooperation from all parties concerned and this includes physicians, dentists, hospitals, Illinois State Department of Public Health, the Governor's Committee heads, and the civilian rehabilitation organizations. No real opposition has developed so far from any group, and after a conference in Washington with General Hines and Watson B. Miller of the War Manpower Commission we were assured that the service was welcome to the Government which will have its hands very full for the next months ahead with the service-connected cases. They were particularly hopeful that we could help out in the milder psychiatric cases not requiring commitment. The State Department of Public Welfare has now assumed a good share of this responsibility and will assume more as rapidly as possible.

As to the future plans we believe this present program is correct and adequate to the needs and on a firm foundation. By adding two or more medical assistant consultants (provided for in the 1945-1946 Illinois State Department of Public Health Budget), one in Chicago and one downstate, it can be expanded as needed to take care of whatever the future holds.

In conclusion it should be added that this plan is the first and most comprehensive one so far put in effect in any state and it is being studied by other states so it may have national importance and may conceivably become a pattern for other states to follow. If so the Illinois State Medical Society may take justifiable pride in its inception.

Respectfully submitted,

HERMON H. COLE, M.D.,
Committee Member.

REPORT OF THE COMMITTEE ON CONSTITUTION AND BY-LAWS

To The Members of The House of Delegates:

At the last meeting of the House of Delegates various changes in the Constitution and By-Laws were presented by this Committee and were accepted by official action. However, one proposed change (Chapter

IX, Section 7) which established a "Committee on Medical Testimony," was rejected and referred to the committee for further study.

The proposed section was presented to the general counsel of the society, and he submitted his opinion. The section as subimtted to Mr. Rawlins, and his subsequent reply is included in this report for your information.

PROPOSED CHANGE IN CONSTITUTION

Section 7. The Committee on Medical Testimony shall be composed of eight members, two of whom shall be elected each year to serve for four years. At the first election under this By-Law two shall be elected for one year, two for two years, two for three years and two for four years.

The House of Delegates at the first meeting during the annual meeting of this Society shall appoint a committee of five including the president of the Society who shall act as chairman, the chairman of the Council, and three members of the House of Delegates, to be designated as the Nominating Committee. This Committee shall present the names of candidates to be elected at the second meeting of the House of Delegates, as members of the Committee on Medical Testimony.

The Committee on Medical Testimony shall have authority to call in members who have been accused of giving unfair testimony in court proceedings, to secure transcripts of court testimony, examine same and determine whether or not any fault exists, to censure and admonish if deemed advisable, and report to the State Department of Registration and Education any gross irregularities that may have arisen.

In cases of censure or admonition, the Committee on Medical Testimony shall submit its report to the Ethical Relations Committee of the component county society for whatever action is deemed advisable.

This committee shall make a report of its activities to the Council each year at the January meeting and to the House of Delegates at the annual meeting.

The above paragraphs were submitted to the general counsel of the Society, and his opinion follows:

November 3, 1944.

Dr. Oscar Hawkinson,
5711 West Chicago Ave.,
Chicago, Illinois,

Dear Dr. Hawkinson:

Some little time ago you left with me a copy of a proposed by-law in re medical testimony which I understand is being considered by the House of Delegates of the Illinois State Medical Society, and you asked for my opinion as to its legality. It is a by-law along the lines of the so-called Minnesota plan concerning which a good deal has been written and said during recent months. It deals with members of the Society.

It is my opinion that it is legal. As a matter of fact, I think most of the things the Committee is authorized to do are things which could legally and properly be done by any individual or group of individuals. Of course, individuals would have no authority to call in members and censure or admonish them. That could only be done by the Committee.

The only criticism which might be made is that the Society is unduly extending the scope of its activities in view of its objects and purposes. However, generally speaking, in matters concerning the conduct of members, the Society necessarily has wide latitude and can adopt any reasonable rules.

Very truly yours,
(Signed) EDWARD W. RAWLINS.

It is not known at this time whether or not the controversial material will be presented to the House of Delegates for further consideration this year, or whether additional committee revision will be given the matter prior to a request for official action.

Respectfully submitted,
Committee on Constitution and By-Laws,
G. C. OTRICH, M.D.,
Chairman,
CHARLES P. BLAIR, M.D.,
*P. R. BLODGETT, M.D.

**In service.*

REPORT OF THE COMMITTEE ON INTERPROFESSIONAL RELATIONS

To The Members of The House of Delegates:

There has been no activity in the Interprofessional Relations Committee during the past year. No special assignments or problems have been presented to the Committee and, because of the tremendous demands upon time and energy and the difficulty in maintaining obligations in public and professional services, it was felt that this was not an appropriate time to undertake any new activities.

Respectfully submitted,
Committee on Interprofessional Relations,
HAROLD J. NOYES, M.D.,
Chairman.
G. C. OTRICH, M.D.,
L. J. HUGHES, M.D.,
E. C. COOK, M.D.,
WALTER STEVENSON, M.D.

REPORT OF FIFTY YEAR CLUB COMMITTEE

To The Members of The House of Delegates:

In January, 1938, the Council of the Illinois State Medical Society, realizing that many physicians in the state had been practicing medicine for fifty years or more, and wishing to do them just honor, organized the Fifty Year Club. The Club is a phantom organization, without officers, dues, or meetings. Those physicians, whether a member of the Society or not, who have been in the practice of medicine for fifty years or more, and are so recommended by their county society, are eligible to membership.

County societies throughout the state have been

holding special meetings to honor these "grand old men of medicine," and the State Society Committee sends a lapel button and a framed certificate of membership for presentation.

We recommend that the county medical society in which the members reside should always sponsor the meeting in which these honors are conferred, unless they combine with some adjoining county medical society.

Since the annual meeting last year in Chicago, the following changes in membership have taken place:

CHICAGO:		
Membership May 1, 1944		124
Deceased during 1944-1945	17	
Deceased before May 1, 1944 and not reported	16	
		33
		91
New members during 1944-1945		26
Membership May 1, 1945		117
DOWNSTATE:		
Membership May 1, 1944		139
Deceased during 1944-1945	29	
Deceased before May 1, 1944 and not reported	37	
		66
		73
New members during 1944-45		22
Membership May 1, 1945		95
Total Club Membership May 1, 1945		212

It has come to my knowledge that there are a number of physicians throughout the state, who are eligible for membership, who have not been so honored. They are men who have dropped out of practice and are not active in Society work who have been forgotten or neglected by the officers of the Societies in the counties in which they reside. There are other physicians who are entitled to this honor who are yet actively engaged in the practice of medicine, but through negligence of the officers and men in the society of the county in which they practice, have not been given this honor.

It is not possible to give an accurate number of the physicians who are now members of the Fifty Year Club as the mortality of these men is quite high and the deaths of many are not promptly reported to the Secretary of the State Society. But to the best of my knowledge the membership does not exceed 250. As there are approximately 12,500 physicians in the state, it is apparent that the Fifty Year Club is a very exclusive club.

Four years ago invitations were sent to every member of the Fifty Year Club to attend a noonday luncheon during the State Medical Meeting. Since that time it has become an annual affair. Last year seventy members of the Fifty Year Club were present at the luncheon. Considering the fact that most of these members were past seventy-five years of age and the membership does not exceed 250, there was a remarkable percentage of membership present.

Many members of the Fifty Year Club are actively engaged in the practice of medicine and will continue until the war ends and younger men of the profession return to take up the work.

"The old family Doctor
Is back with us once more.
As Majors and as Captains
All the young have gone to war,
And Doctors long past sixty
Are on duty night and day
Taking care of all their patients
In the good old-fashioned way.
The little grip he carries
Shows the signs of wear and tear,
Like the Doctor it has served long,
Through weather foul and fair.
And the same things are in it,
All the remedies of old;
The blue and purple tablets,
Good for breaking up a cold.
And until the war is ended,
Here at home I'm sure
The old family Doctor
Every ill that comes he'll cure."

Respectfully submitted,
Fifty Year Club Committee,
ANDY HALL, M.D.,
Chairman.
C. E. WILKINSON, M.D.,
E. H. OCHSNER, M.D.,
H. O. MUNSON, M.D.

REPORT OF THE WOMAN'S AUXILIARY

To The Members of The House of Delegates:

As President of the Woman's Auxiliary to the Illinois State Medical Society, I wish to submit the following report:

1. MEETINGS:

In all, four meetings of the Board of Directors of the Woman's Auxiliary to the Illinois State Medical Society have been held during the past year. This includes a post-convention meeting. Due to the fact that the Woman's Auxiliary had no annual meeting, a special Board Meeting was held in May to close the business of the preceding year and to formulate plans for the ensuing year.

2. OFFICERS:

Because there was no House of Delegates to elect new officers, the same ones will continue in office for the coming year.

3. ORGANIZATION AND MEMBERSHIP:

The principle effort of the Auxiliary this year was put into an attempt to hold the organization intact

during this war period. Therefore, it is gratifying to be able to report that there are still sixteen counties organized, although one is inactive for the duration, but paying dues. Most counties are paying the State and National dues for the members whose husbands are in the service. However, this may not be continued by all counties next year, and will cause a noticeable decrease in the income of the State Auxiliary. The membership is 988.

4. BENEVOLENCE:

As of March, the treasurer sent $978.90 to the Illinois State Medical Society for this fund. By the end of the year in May, this should increase to well over a thousand dollars as there are several large checks yet to come in.

5. PUBLIC RELATIONS:

On advice of the Advisory Committee of the Illinois State Medical Society every effort has been made to increase the liaison contacts with other organizations throughout the state. A number of counties again held Public Relations programs while others, finding this impossible, have concentrated on increasing their contacts through the War Service work.

6. LEGISLATION:

It is encouraging to find that doctors' wives belonging to the Auxiliary are becoming better informed on the multitude of medical legislation, both state and national, which is now facing us. The advice and instruction of the Advisory Committee and Mr. Neal are followed in all matters of this nature. The Journal of the Illinois State Medical Society and the Journal of the American Medical Association are studied very carefully.

7. HYGEIA:

Hygeia, the authentic health magazine, is introduced and placed in schools, libraries, hospitals, and many other public places by the Woman's Auxiliary as its biggest effort in health education. This year Illinois won honorable mention for the number of subscriptions sent in.

8. WAR SERVICE:

The Woman's Auxiliary has participated in many war activities such as: Red Cross, first aid, home nursing, blood banks, war bonds, entertaining of service men and women, motor corps, and making and obtaining many comforts and necessities for the wounded in the Army and Navy hospitals.

9. SCHOOL OF INSTRUCTION:

This has been a need felt for many years. Two such schools were held this year, one in Cook County and the other in Peoria with twelve counties participating. The reception of this venture was most enthusiastic although it is still in the formative stage. A final conclusion of the results will have to wait for a few years.

10. AS PRESIDENT:

I have attended all possible meetings of Cook County when I was not out of the city on Auxiliary business. The Branches of Cook County visited were Aux Plaines, North Shore, Englewood and Stock Yards. Conflicting dates prevented the acceptance of several other invitations both in Chicago and down state. The counties visited were Peoria, Bureau, Henry, Vermilion, Logan and St. Clair.

In November I attended the first National Conference set up under the new Constitution and By-Laws of the Woman's Auxiliary to the American Medical Association. All recommendations of the National Auxiliary have been carefully studied and carried out whenever advisable.

All chairmen of standing committees were given direct instructions at the beginning of the year and a close personal contact maintained throughout.

In the name of the Woman's Auxiliary to the Illinois State Medical Society, I wish to express its sincere appreciation for your cooperation, and to the Advisory Committee for its continued advice and encouragement which has meant much to the Auxiliary.

Respectfully submitted,

The Woman's Auxiliary,

(MRS. ALFRED F.) ESTELLA GAREISS,

President.

EASIER ACCESS TO PUBLIC BUILDINGS URGED FOR HANDICAPPED PERSONS

A recently inaugurated campaign by the National Society for Crippled Children and Adults to construct new public buildings with ground level entries, elevators between floors and the elimination of all unnecessary steps should help to "decrease the number of accidents among the handicapped as well as greatly increase their ability to perform business activities and seek pleasure with greater frequency and ease," says the August 18 issue of *The Journal of the American Medical Association.*

"This society," *The Journal* says, "also urges the remodeling of existing buildings with long flights of stairs, to provide ground level entries, elevators, ramps and other practicable measures aimed at the elimination or amelioration of impediments to ready access. Patients with heart disease, crippling illnesses, missing limbs or other disorders of locomotion form an increasing proportion of the population, both because of the war and because of the lengthened average age."

News of the State

PERSONALS · COMING EVENTS · MARRIAGES · DEATHS

★ WAR SERVICE ACTIVITIES ★

CHRISTIAN COUNTY

Lt. Col. R. B. Siegert of Pana, who was nearing the end of his third year in the United States Army Medical Corps has received his honorable discharge and has returned to Pana to practice medicine and surgery.

COOK COUNTY

For meritorious service in supervising and aiding in the organization for the evacuation of the wounded, Major Brendan P. Phibbs, formerly of Winnetka, Ill., was recently awarded the Bronze Star. As a surgeon with the headquarters of the combat command battalion of the 12th Armored Division, Major Phibbs frequently exposed himself to enemy fire to see that evacuation was accomplished expeditiously and by the safest routes. Dr. Phibbs graduated from Northwestern University Medical School, Chicago, in 1942 and entered the service in June 1942.

Lieut. Col. Manuel E. Lichtenstein, formerly of Chicago, was recently awarded the Brazilian decoration "Medal de Guerra." The presentation was made by General Mascarenhas on May 29, 1945, in the name of the President of Brazil. Dr. Lichtenstein organized the medical staff of the Brazilian expeditionary force assigned to an evacuation hospital and successfully established the practice of modern surgical methods for the care of battle casualties among Brazilian troops during the Italian campaign. Dr. Lichtenstein is also the recipient of the Bronze Star. He graduated from Rush Medical College, Chicago, in 1925 and entered the service Oct. 15, 1942.

Capt. John B. Condon, formerly of Chicago, was recently awarded the Bronze Star "for meritorious service in connection with military operations against the enemy from Feb. 4, 1945 to Feb. 12, 1945 in France, while located at Fortschwihr, when the clearing station under Captain Condon's command was forced to operate considerably under strength. Casualties required the constant care of this medical officer, and exceedingly adverse weather conditions added considerably to Captain Condon's problems, as he was forced to operate in tents. The superior performance of duty rendered by this officer reflects great credit on himself and on the Medical Corps." Dr. Condon graduated from Loyola University School of Medicine, Chicago, in 1940 and entered the service Jan. 5, 1943.

Lt. Commander Joseph Edward Verhaag who had an office at 20 North Wacker Drive, Chicago, has sent the following message to the Illinois Medical Journal —

"Copies of the Illinois Medical Journal have been reaching me regularly and I have enjoyed the articles and news they have contained. I am stationed on an attack transport in the Pacific and am glad to announce my promotion to Commander, U. S. Naval Reserve. My best wishes for the continued success of the Illinois Medical Journal."

Major Walter C. Bornemeier, first doctor to be released from the Army under the Medical Corps point system has returned to his practice in Chicago and to the staff of the Illinois Masonic Hospital. Major Bornemeier left the 52nd Station Hospital in Naples, where he served as assistant chief of surgery, July 10, three years from the day he said good bye to the Illinois Masonic Hospital to enter the Army.

John H. Johnston, medical officer and allergist at the Mayo General Hospital, formerly of 4513 North Hamilton Street, Chicago, has been promoted from Captain to Major.

DE KALB COUNTY

Major E. W. Telford of DeKalb is home after being discharged from the service and has resumed his practice of medicine in DeKalb. He

has been in service four years and four months. He was with the 129th Infantry in the Pacific theater for a year and was then re-assigned to an evacuation hospital surgical staff, caring for evacuees from General Patton's Third Army.

FULTON COUNTY

Captain Frank D. Jacobs of Farmington has been assigned for duty to the Mayo General Hospital in Galesburg. He has been on duty in England, France and Germany with the U. S. Medical Corps.

MARION COUNTY

Major Harry DeWitt Nesmith, formerly of Salem, Ill., was recently awarded the Bronze Star for meritorious achievement in connection with military operations against the enemy from June 1, 1944 to March 31, 1945. At the present time he is stationed in Germany. Dr. Nesmith graduated from the University of Illinois College of Medicine, Chicago, in 1939 and entered the service in March 1941.

PEORIA COUNTY

Phillip R. McGrath of Peoria, who has served for the last two and one-half years as a lieutenant commander in the Navy, has been placed on inactive duty and is re-opening his Peoria office, specializing in eye, ear, nose and throat cases.

ROCK ISLAND COUNTY

F. J. Cenedella and J. G. Gustafson of the Rock Island County Medical Society has received promotions to Major in the Medical Corps, United States Army. Captain F. X. Meier of Milan and Captain Samuel P. Durr of Rock Island have been at home on leave.

ST. CLAIR COUNTY

Captain H. P. Dexheimer of O'Fallon has been spending some time with his family after serving two years in the China-Burma theater of war with the U. S. Army.

Colonel Paul G. Hansen, East St. Louis, attached to a medical detachment in China, has been awarded the People's Hero Medal by the Chinese Government. For the last two years he has been in charge of hospitals in Central and Western China. Some time ago he was awarded the Bronze Star by the U. S. Army.

GENERAL NEWS

COOK COUNTY

Dr. Anton J. Carlson, emeritus professor of physiology, University of Chicago School of Medicine, has been appointed on a part time basis as director of the Research Council on Problems of Alcohol, New York.

Dr. Carl C. Pfeiffer has been appointed professor and head of the department of pharmacology, materia medica and therapeutics at the University of Illinois College of Medicine, effective on his release from the U. S. Navy, August 15. Dr. Pfeiffer graduated at the University of Chicago School of Medicine in 1937. He was pharmacologist with Parke, Davis & Co. from 1941 to 1943, when he entered the Navy. Earl Randall Loew, Ph.D., research pharmacologist with Parke, Davis & Co., has been named associate professor of pharmacology, materia medica and therapeutics, and Dr. Klaus R. W. Unna, formerly research associate with Merck Institute of Therapeutic Research, Rahway, N. J., and recently instructor in pharmacology, University of Pennsylvania School of Medicine, Philadelphia, has been named assistant professor in the department of pharmacology at Illinois.

Mr. Tom Jones, professor of medical and dental illustration, University of Illinois Colleges of Medicine, Dentistry and Pharmacy, Chicago, was elected president of the Association of Medical Illustrators at its organization meeting in Chicago, July 16-19. Other officers include Mr. Willard C. Shepard, art editor, W. B. Saunders, publishing company, Philadelphia, vice president; Muriel McLatchie, Massachusetts General Hospital, Boston, secretary, and Elizabeth Brödel, New York, treasurer. The association was formed to promote the study and to encourage the advancement of medical illustration and allied fields of visual education to promote understanding and cooperation with the medical and dental professions, including public health and nursing and to advance medical education. The association begins with a charter membership of about fifty-four, and Philadelphia was tentatively selected as the site for a meeting in 1946. A dinner honoring the delegates to the organization meeting was given July 17. The association will include members in Latin America and Canada.

The Illinois Society for Mental Hygiene is offering its services in the planning of educational programs to promote better understanding of the emotional adjustments of civilians and veterans. The service is available, without charge, to organizations wishing a list of speakers, a series of appropriate movies and a selection of literature for distribution or sale. Arrangements for hall, speakers, movies and audience will be left to the organization wishing the planning service. If the group wishes the Illinois Society for Mental Hygiene to conduct programs, a charge will be made for the cost price of the speakers' fees, movies and any other expense incurred. Additional information may be obtained from the Illinois Society for Mental Hygiene, 343 South Dearborn Street, Chicago 4.

The department of otolaryngology, University of Illinois College of Medicine, will offer a special course in bronchoesophagology, October 15-27, under the personal direction of Dr. Paul Holinger, assistant professor of laryngology, rhinology and otology. The course will consist of didactic lectures, animal and cadaver demonstrations, practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics and other work. Registration will be closed when the limited number of twelve applications of physicians have been received. Additional information may be obtained from the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12.

IROQUOIS COUNTY

Dr. William R. Roberts, Cissna Park, was recently chosen "Man of the Week" by Danville *Commerical News*. In his nomination for the honor, credit was given to Dr. Roberts for his service to the community and his recent admission to membership in the fifty year club of the Illinois State Medical Society. Two of his sons, both physicians and now in service, were formerly associated with him.

McLEAN COUNTY

Edwin M. Minnick of Danvers, formerly of Kewance and Bradford, was presented the fifty-year pin and certificate of the Illinois State Medical Society by the McLean County Medical Society at its June 12th meeting. Doctor Minnick graduated from Rush Medical College in 1895. He has always been active in the affairs of Danvers and has served as president of the board of directors of the Public Library for many years.

MADISON COUNTY

On August 19, Doctor Carlos E. Trovilion of Alton and his wife celebrated their fiftieth wedding anniversary.

Doctor R. W. Binney of Granite City has been named chief surgeon of the new Davis Hospital on Milton Road in Wood River Township. Doctor L. D. Darner of Wood River will direct the hospital.

MOULTRIE COUNTY

Doctor A. D. Miller of Sullivan is probably one of the oldest physicians in the state maintaining a general practice. He is now in his 53rd year of general practice in Sullivan. Last June Doctor and Mrs. Miller observed their golden wedding anniversary.

PEORIA COUNTY

Sandor Horwitz of Peoria recently completed fifty years in the practice of medicine.

ROCK ISLAND COUNTY

Due to the prevalence of Tinea Capitis cases among school children the County Society has appointed a Ringworm Committee whose function has been to formulate regulations for the control of spread of the disease and also in an additional capacity to enlighten the public concerning the important features of the infection. For this purpose the committee has written a series of articles for the press.

SANGAMON COUNTY

Governor Green has appointed an advisory council to assist the state health department in making a detailed study of all hospital facilities in Illinois and in developing a long-range construction program. Robert S. Berghoff, President-Elect of the Illinois State Medical Society has been made chairman of the advisory group which includes representatives of public health, welfare hospital and civic organizations and legislators, educators and physicians.

WARREN COUNTY

A sum of more than $1,150 has accumulated at the Monmouth hospital as a memorial to Doctor Joseph Leslie Sherrick in the year that has passed since his death.

MARRIAGES

Floyd Samuel Barringer, Emden, to Miss Winifred Lois Wain of Forest Hills, N. Y., in Ripley, England, June 2.

H. W. Davis to Miss Ruth Kenne, both of Alton, June 16th.

DEATHS

Clay Alder, Chicago; University of Illinois College of Medicine, 1915. Was on the staff of Augustana hospital; had practiced medicine in Chicago 30 years. Died August 13th at the age of 58.

William Patrick Cannon, retired; Somonauk; University of Illinois College of Medicine, 1905. Had practiced medicine in Kankakee 29 years before moving to Somonauk. Was a captain in World War I and district surgeon for Illinois Central Railroad for 25 years. Died August 8th, aged 65.

Joseph V. Capel, Harrisburg; St. Louis College of Physicians and Surgeons, 1894. Had practiced medicine in Harrisburg for 51 years and was president of the Harrisburg National Bank. Died August 7th, at the age of 78.

William H. Enos, Jerseyville; Pulte Medical College, Cincinnati, 1880. Had practiced medicine in Madison County for the past fifty years. Died July 27th, aged 90.

George H. Ensminger, Chicago; Medico-Chirurgical College of Philadelphia, 1905. Had practiced medicine

in Chicago since 1907. Served as chief of the eye clinic of Mercy hospital; clinical professor of opthalmology at Loyola University School of Medicine; health officer of Glen Ellyn, medical consultant to several railroads. Died of a heart ailment in Illinois Central hospital, aged 67, on August 23rd.

Andrew Joseph Erickson, Chicago; Chicago Medical School, 1921. Was school physician for the Chicago Health Department. Died in St. Anne's hospital of injuries suffered in an automobile accident, in July, at the age of 58.

Fauntleroy Flinn, Decatur; Medical College of Virginia, 1914. Director of the radiological departments of St. Mary's and Wabash Employes' hospitals in Decatur, St. Clara's and Deaconess hospitals in Lincoln, St. Anthony's in Effingham, Shelby Memorial hospital in Shelbyville and Kirby Hospital in Monticello. Past president of the Decatur Medical Society and Illinois Radiological Society. Died in St. Mary's hospital July 26th at the age of 55.

Michael A. Griffin, Chicago; Rush Medical College, 1896. Had practiced medicine nearly half a century. Died August 23, aged 76.

Louis J. Hajdusek, Chicago; Chicago College of Medicine andSurgery, 1912. Was senior staff member of St. Mary of Nazreth hospital. Died July 30th while visiting a patient, was 58 years of age.

William K. Jaques, Chicago; Northwestern University Medical School, 1887. Practiced medicine in Chicago for 58 years. Died in August at the age of 86.

Anthony Gus Kerasotes, Springfield; St. Louis University School of Medicine, 1940. Entered the medical corps of the U. S. Naval Reserve as a lieutenant (jg) on Sept. 10, 1942; received training at Parris Island, S. C., and served as medical officer at Savannah, Ga., naval base; participated in the invasions of North Africa and Sicily and the landings in Italy; served on the board of the U.S.S. Leary when the vessel was torpedoed in the Atlantic area while engaged in an antisubmarine patrol; promoted to lieutenant; reported missing in action as of Dec. 24, 1943; presumptive date of death, Dec. 25, 1944, aged 32.

John W. Kramps, Chicago; Rush Medical College, 1898. Member of St. Elizabeth Hospital staff since graduation from medical school. Died August 16th, aged 77.

Abraham L. Morris, Chicago; Bennett Loyola University, 1912. Had practiced medicine on the south side for 20 years. Died in Woodlawn hospital, aged 62, on July 27th.

Wallace Welsh Munsie, Decatur; Hahnemann Medical College of Philadelphia, 1940. On staff of Decatur and Macon County Hospital and St. Mary's Hospital; secretary of the Decatur and Macon County Medical Society in 1944. Died suddenly of a heart attack at the age of 32 on July 25th.

Harry Dunlap Wiley, Glencoe; Rush Medical College, 1899. Served as major in the medical corps in World War I. Died in Highland Park hospital which he helped found and where he had been a staff member, on August 20th, aged 74.

Thomas J. Williams, Evanston; State University of Iowa College of Medicine, 1908. Head of Department of Ophthalmology at Illinois Post-Graduate Medical School for 10 years; was chairman of the staff of Eye, Ear, Nose and Throat, Illinois Masonic Hospital. Served as captain in the Army Medical Corps in World War I. Died in his home, August 10th, at the age of 63.

Very little has been learned in the field of preventive medicine that can be of much use for the individual person who acquires rheumatic fever and, in this respect, we must continue to do the best we know, which is little more than what was known to, and practiced by, the earlier physicians. But in the field of public health, great advances have been made and much can be accomplished, provided certain measures can be carried out for the whole community which result in real protection for the individual. This same situation is equally true for several other important diseases; for example, tuberculosis and infantile paralysis in which, in each case, the cause of the disease and the no specific form of treatment exists with which the way in which it is spread is now well known, but where individual patient may be relieved. Hugh McCulloch, M.D., Minn. Med., Dec. 1944.

We need to impress upon many, many people that periodic X-ray examination of the chest is an extremely valuable safeguard of health. We need also to stress forcibly the fact that isolation, in a sanatorium or other institution, of tuberculous patients having tubercle bacilli in their sputum, is most desirable.

We must show and teach that protection of those recovered from active tuberculosis is financially and socially well worth while. We must teach with renewed and strengthened energy, the need of maintaining adequate living standards and the economic advantages of rehabilitation. Fred H. Heise, M.D., NTA Bull., Jan. 1945.



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the

aged

patient



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against peptic ulcer recurrence



In view of the tendency of peptic ulcer to recur in the spring and autumn, many clinicians return their patients to *full ulcer therapy*—diet, rest, antacids—from the middle of September through October and from the beginning of March through the middle of April. • Amphojel provides safe, dependable antacid medication admirably suited to offset episodes of hyperacidity. It inactivates gastric secretions without alkalinization, mildly and efficiently. Supplied in 12-fluidounce bottles.

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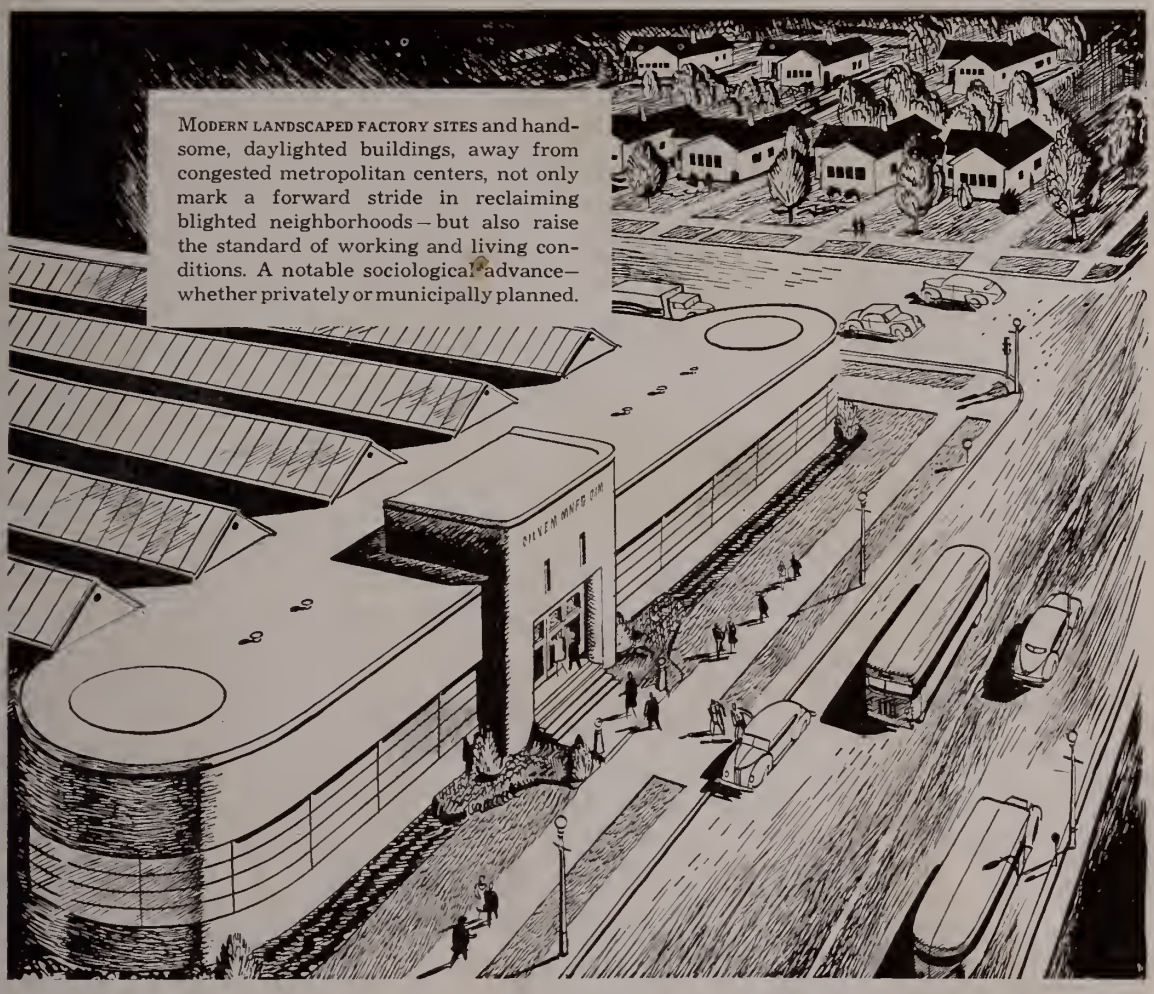
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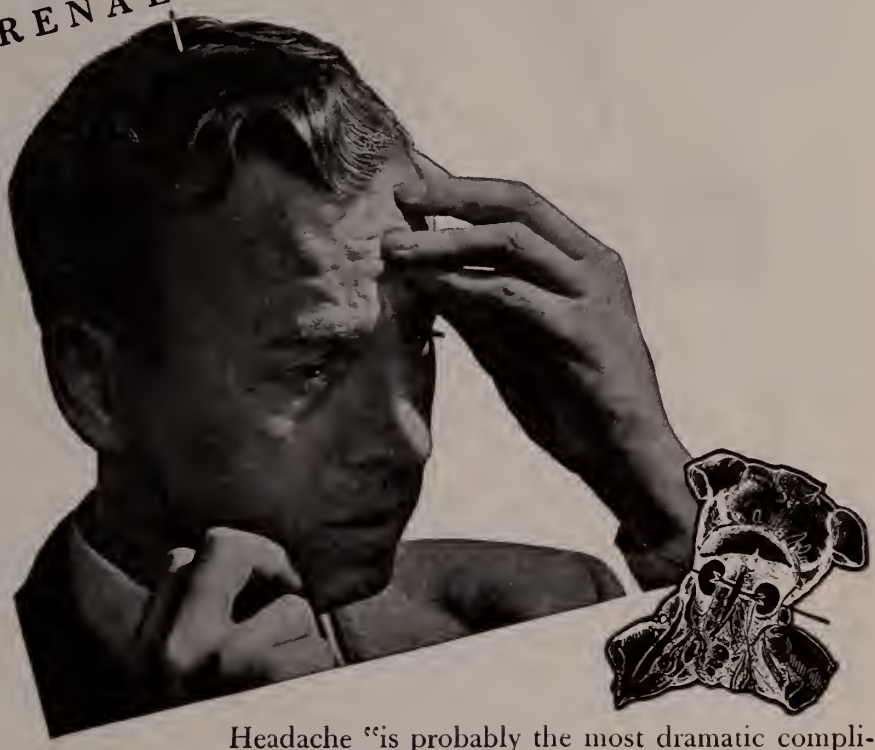
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*McDonald, R. H.: (Headaches of renal origin): M. Clin. N. Am. 24:365 (March), 1940.

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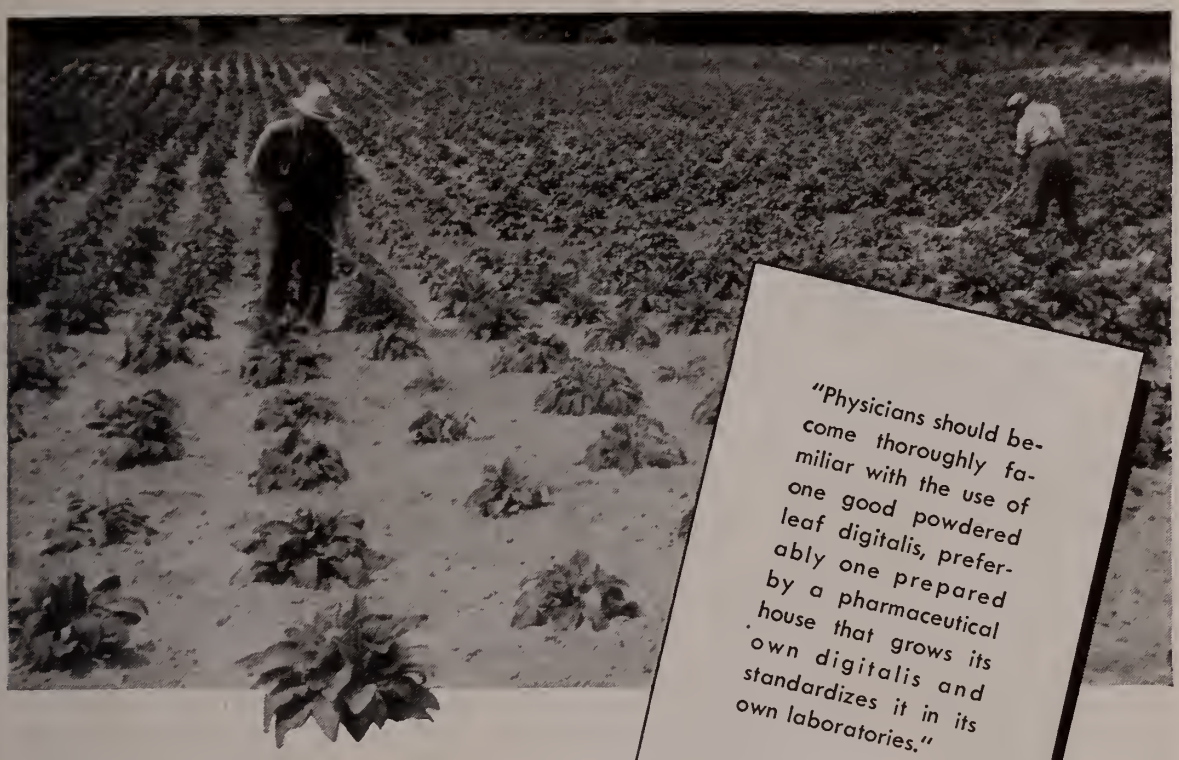
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1. Herrmann, G. R.; Decherd, G. M. Jr., and McKinley, W. F.; Digitalis Poisoning, J.A.M.A. 126:760 (Nov. 18) 1944.

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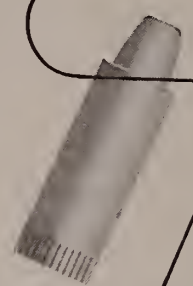
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Shambaugh, G. E., Jr.:
J. Iowa State Med. Soc. 31:373-377.

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Peoria, Ill.

Rain on a Cabin Roof

Far away in the wilds of the Northland
Isolation is full and complete.
Here we live by ourselves in abstraction,
Here we all of our troubles delete.

Here we paddle the lakes clear as crystal,
Traverse portages winding and wild,
We shoot rapids of rushing white water
With exuberant joy of a child.

Here are beautiful islands by hundreds;
Here are millions of birches and pine;
There is peace and contentment abounding
And the air is as potent as wine.

After days that are gorgeous with sunshine
And we've fished in the lakes clear and deep
And have lolled by big cheery fire-place
And have gone to our cabins for sleep.

Then there comes a sound peaceful and soothing,
And there's no one can offer disproof,
That no sound may be heard quite as restful
As the patter of rain on the roof.

When we're deep in the bush in the Northland
Far apart from the world and aloof,
There is nothing so friendly and cosy
As the patter of rain on the roof.

RETROSPECTION

With our dead line in the offing, every season we start golfing with a wealth of apprehension and of doubt. With the closing of the season we look back to find the reason for the inconsistencies that lurk about.

Uniformity is lacking and we feel that we are cracking when we cannot make the little ball behave. We then reach the full conclusion that it's all a sad illusion and admit that we have one foot in the grave.

But with compctition faster we at times play like a master, but we never know just why or where or when. But to always break an eighty is a problem somewhat weighty when a man has passed his three score years and ten.

There are days when things go sweetly and we par

(*Continued on page* 56)

PEPTIC ULCER MANAGEMENT

Knox Gelatine is successfully used in the frequent between-meal feedings that are often desirable in the management of peptic ulcer.

Given at hourly intervals, Knox Gelatine has provided a satisfactory control of the gastric secretions and gives relief from the painful symptoms.

A *Special Ulcer Diet* described in the Knox booklet, "Peptic Ulcer Dietary," has been prescribed by many physicians. It is a complete diet . . . bland and liberal in calories and protein. We will be happy to send you as many copies of it as you wish.

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THE effectiveness of Mercurochrome has been demonstrated by more than twenty years of extensive clinical use. For professional convenience Mercurochrome is supplied in four forms—Aqueous Solution in Applicator Bottles for the treatment of minor wounds, Surgical Solution for preoperative skin disinfection, Tablets and Powder from which solutions of any desired concentration may readily be prepared.

Mercurochrome

(H. W. & D. brand of merbromin, dibromoxymercurifluorescein-sodium)

is economical because stock solutions may be dispensed quickly and at low cost. Stock solutions keep indefinitely.

Mercurochrome is antiseptic and relatively non-irritating and non-toxic in wounds.

Complete literature will be furnished on request.



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BALTIMORE, MARYLAND

P. R. N. (Continued)

the course quite neatly and the next day shoot a ninety in a rage. To predict our score is risky for our golf is not like whiskey, and this game of ours does not improve with age.

It is hard to be phlegmatic with a game that's so erratic, but it does no good to fume and fuss we find; we will get more satisfaction and the game still have attraction if we're smart enough to keep our age in mind.

IRONY

Since irony constitutes a form of humor,
What endless chance we doctors offer folks,
When we become the sick and suffering patients:
What countless opportunities for jokes!

Otologists who have a mastoiditis,
Are things so very funny
They make our lives as sunny
As surgeons with acute appendicitis.

Internists with pneumonia and pleuritis
Give most enchanting pleasure
And joy beyond all measure,
Like gynecologists with salpingitis.

Psychiatrists who always have psychosis,
Cause humor as amusing,
Facetious and confusing
As dermatologist's pediculosis.

Rhinologists who howl with sinusitis,
Are comic and so snappy
They make us glad and happy
Like laryngologists with tonsillitis.

Neurologists who suffer from glioma
Are matters of frivolity,
And we are filled with jollity
At ophthalmologist's acute glaucoma.

An epidemiologist with rabies
Is just as gayly laughable
And frivilous and chaffable
As female obstetricians having babies.

Urologists who have acute retention
Cause mirthful joviality
And gleeful geniality
Like baby doctors colicky distension.

An orthopedist in a cast looks merry,
And gives a cheery pleasantry
Refreshing in its levity,
Like enterologists with dysentery.

BUT —
The thing that brings us cheer and broadest smiles,
And deepest jocularity
And loudest wild hilarity
Is proctocalogists with bleeding piles.

(*Continued on page* 58)



clearly defined

THE MALE CLIMACTERIC SYNDROME

is now recognized as a clearly defined entity, and may be suspected to be present when middle-aged men in the prime of life complain of tiredness, nervousness, insomnia, vague pains and impotence.

ORETON

Therapy with *Oreton*, testosterone propionate, frequently alleviates these manifestations. If they are due to insufficient hormone, and restores male climacteric patients to former physical and mental vigor.

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P. R. N. (Continued)

Reds

There are dreary reds,
There are cheery reds,
There are reds that are happy and glad.

There are trustful reds,
There are lustful reds,
There are reds that are gloomy and sad.

There are lighting reds,
There are fighting reds,
There are reds that will drive us stark mad.

And majestic reds,
And domestic reds,
There are reds that are good and are bad.

We know the reds of morning skies,
Enticing reds of wine,
We know the gory reds of war,
Of autumn tinted vine.

We know the reds of garden flowers,
The reds of bloody strife,
The cheery reds of firelight glow,
The red on surgeons knife.

We know the reds of lucious fruit,
The bows in children's hair,
The red, red rash of vile disease,
The garments women wear.

We know bookkeepers doleful red,
Devouring reds of fire,
The corner light that bids us stop,
The red of funeral pyre.

We know the reds of countless birds,
The red of bleary eyes,
The raucous reds at cannon's mouth,
The peace of sunset skies.

But the merriest red
And the cheeriest red
And the red that is gayest of all,
As its brightness discloses,
Are the Paul's Scarlet roses,
As they laugh o'er a fence or a wall.

* * *

Professor Paresis asserts —

I like to do my resting
When skies are bright and clear,
And no one should be working
When days are dull and drear;
And so it might appear, Sir,
I dodge when work is near,
I rest and sit and sit and rest
And drink my ginger beer.

Attaining Perfection...



The attainment of perfection is not a simple or easy task. Only those who apply themselves unreservedly can hope to reach this goal.

At Harrower we are pledged to continuous application of rigid scientific and technical controls in the development of specialized products which will continue to merit the increasing confidence of the medical profession.

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Book Review

PEDIATRIC NURSING; By Abraham Levinson, B.S., M.D., Associate Professor of Pediatrics, Northwestern University Medical School; Professor of Pediatrics, Cook County Graduate School of Medicine; Attending Pediatrician, Children's Division of the Cook County Hospital; Senior Attending Pediatrician, Sarah Morris Hospital for Children of the Michael Reese Hospital; Senior Attending Pediatrician, Mt. Sinai Hospital, Chicago. Third Edition, Rewritten and Reset. Illustrated with 53 Engravings and a Color Plate. Lea and Febiger, 1945. Philadelphia. Price $3.00.

Again Dr. Abraham Levinson has revised his "Pediatric Nursing", and the third edition has been released by Lea and Febiger. Physicians and hospitals providing this specialized training for our Illinois nurses will find a comprehensive and complete coverage for undergraduates. Perhaps the pediatrician desiring a nurse for his office work would be interested in seeing that she used this text as a means of review and of making her services more valuable to him.

The discovery of the sulfonamides and also of penicillin since the second edition of this volume appeared, necessitated a revision of the text, and the addition of new nursing technique.

The arrangement of the material is conducive to quick and accurate reference work. Part I gives in detail the general considerations of the child in health and disease. It deals with the anatomy, physiology and development of the newborn, the special handling given the premature, feeding problems in the hospital and at home, and methods of examination and treatment. Part II discusses the various diseases of childhood, their diagnosis, prevention, treatment and management. Part III deftly handles the psychologic and sociologic aspects of pediatric nursing and gives information seldom found in teaching textbooks in this field.

Illinois physicians, especially those teaching in the nursing schools, will find this material accurate, complete and a valuable addition to teaching equipment.

F. C. Z.

Books Received

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

BEDSIDE CLINICS OF FRANCIS D. MURPHY, M.D., F.A.C.P., Professor and Head of the Department of Medicine of the Marquette University Medical School

(*Continued on page* 62)

FOR PRENATAL CARE

DURING pregnancy, not only must an adequate intake of calcium and phosphorus be assured, but also a liberal supply of vitamin D for peak calcium metabolism . . . vitamin B_1 for sound nerves and the amelioration of hyperemesis gravidarum . . . and vitamin C, to supply the greatly increased requirements of pregnancy and lactation.

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Walker's
DICALCIUM PHOSPHATE WITH VITAMINS B-C-D

and Clinical Director of the Milwaukee County General Hospital and Emergency Unit. Volume I. Marquette University Press, Milwaukee, 1945.

DISEASES OF THE BREAST: Diagnosis, Pathology, Treatment. By Charles F. Geschickter, M.A., M.D., Lieut. Commander, Medical Corps, United States Naval Reserve; Director of the Francis P. Garvan Cancer Research Laboratory; Pathologist, St. Agnes Hospital, Baltimore. With a special Section on Treatment in Collaboration with Murray M. Copeland, A.B., M.D., F.A.C.S., Instructor in Surgery, Johns Hopkins Medical School, Visiting Surgeon and Assistant Oncologist, University Hospital, University of Maryland Medical School, Visiting Oncologist, Baltimore City Hospitals. 593 Illustrations. Second Edition. J. B. Lippincott Company, Philadelphia and London. Price $12.00.

DIET MANUAL FOR HOME NURSING: By Marie V. Krause, M.S., Eleanora Sense, M.S., M. Barrows and Company, Inc., New York. Price $2.00.

PEDIATRIC NURSING; By Abraham Levinson, B.S., M.D., Associate Professor of Pediatrics, Northwestern University Medical School; Professor of Pediatrics, Cook County Graduate School of Medicine; Attending Pediatrician, Children's Division of the Cook County Hospital; Senior Attending Pediatrician, Sarah Morris Hospital for Children of the Michael Reese Hospital; Senior Attending Pediatrician, Mt. Sinai Hospital, Chicago. Third Edition, Rewritten and Reset. Illustrated with 53 Engravings and a Colored Plate. Philadelphia. Lea and Febiger, 1945. Price $3.00.

TREATMENT IN GENERAL PRACTICE: By Harry Beckman, M.D., Professor of Pharmacology, Marquette University, School of Medicine, Milwaukee, Wisconsin. Fifth Edition, Reset. 1070 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1945. Price $10.00.

It is not unreasonable to think that, in the future, all people will be tuberculin tested and X-rayed, under the county area plan, the reactors isolated and given modern successful medical treatment. Many universities, high schools, grade schools, industrial organizations and certain communities have already conducted tuberculin tests or made use of X-ray films, and it is greatly to be hoped that this will continue to expand. H. R. Smith, M.D., Am. Rev. Tbc., December, 1944.

The tuberculosis mortality rate among males in practically all age groups shows a consistent relationship to size of community. The rate in large cities is considerably higher than in the intermediate-sized cities and the rate in the latter is in turn higher than that of the rural areas. Jacob Yerushalmy, M.D. & Charlotte Silverman, M.D., Am. Rev. Tbc., May, 1945.

For the Failing Heart

Phyllicin



A "theophylline" for oral administration — quick acting and well tolerated. For the relief of cardiac distress and pain, to diminish dyspnoea and to reduce edema.

DOSE: 1 or 2 tablets (4 grains each) after meals.

Phyllicin, brand of theophylline-calcium salicylate, Trade Mark reg. U. S. Pat. Off.

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Only from the proteins of the foods eaten can the organism derive the protein substances required for these complex purposes.

Among man's protein foods meat ranks high, not only because of the percentage of protein contained, but principally because its protein is of highest biologic quality, applicable wherever protein is required.

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PENICILLIN AND SULFADIAZINE VERY EFFECTIVE IN PNEUMONIA

Study By Seven Army Physicians Reveals Response From Both Agents Is Almost Identical; Cut Death Rate Sharply

Which is more effective in the treatment of pneumonia — penicillin or sulfadiazine?

Seven army doctors, reporting results of an extensive study in the August 25 issue of *The Journal of the American Medical Association*, said that the response from both agents was almost identical, the only difference being a more abrupt fall in temperature and fewer instances of spreading infection with penicillin.

"It is not to be inferred, however," the doctors said, "that penicillin and sulfadiazine are therefore of equal value in the treatment of all cases of pneumonia, for such is not the case. The patients on whom the study was made were vigorous, healthy young adults of whom treatment was instituted early.

"The important conclusion to be drawn, then, is that since adequate doses of either drug will produce an equally satisfactory and, indeed, almost identical response, the lower cost and greater ease of administration may make sulfadiazine the drug of choice in this group of patients. Once the problems of cost and administration are overcome, however, penicillin will be favored because of its lack of toxicity and the probability that penicillin resistant strains of pneumococci will be encountered rarely if at all, whereas with the sulfonamides resistant strains occur in two to six per cent of the cases."

The doctors, who made the study at the regional Station Hospital, Fort Bragg, N. C., are Lt. Col. J. Murray Kinsman, Lt. Col. Worth B. Daniels, Capt. Samuel Cohen, Capt. Joseph P. Mc Cracken, Capt. Constance A. D'Alonzo, Lt. Samuel P. Martin and Lt. William M. M. Kirby, all of the Medical Corps, Army of the United States.

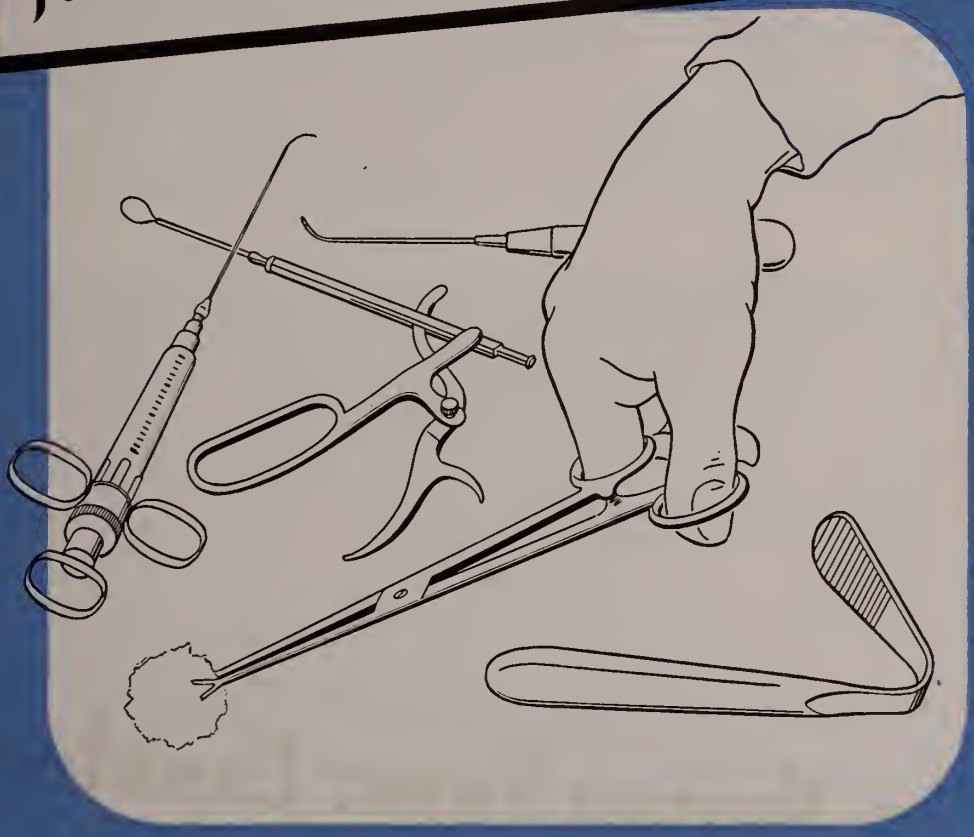
Use of the two drugs has helped to bring about one of the striking achievements of military medicine, namely the reduction in the mortality rate of pneumonia from 28 per cent during

(*Continued on page* 66)

Recommend NATIONAL
CITRATE OF MAGNESIA U.S.P.
Therapeutic Indications of ACIDOSIS
It restores the alkali reserve of the body, thereby overcoming the toxemia which is in the blood.
THE FAVORITE LAXATIVE WITH MANY PHYSICIANS
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Simple and uniquely effective, the post-tonsillectomy use of Aspergum

1. provides welcome local analgesia
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3. laves dry, irritated mucosa with a continued soothing flow of saliva
4. by producing increased comfort and encouraging resumption of a suitable diet, hastens convalescence.

Supported by extensive, successful clinical experience over a period of many years, Aspergum is acceptable and effective in the case of those many patients—including children—who will not or cannot gargle properly, or who experience difficulty in swallowing tablets. Ethically promoted. White Laboratories, Inc., Pharmaceutical Manufacturers, Newark 2, New Jersey.

Dillard's **Aspergum**

PNEUMONIA (Continued)

World War I to approximately 0.7 per cent during the present war.

The effectiveness of penicillin and sulfadiazine in pneumonia treatment can be seen from the fact that of the 255 patients concerned with the study, there were no fatalities.

The doctors believe that patients seriously ill with the disease should be treated with penicillin because of its greater action against the pneumonia germ.

"From the dramatic results obtained in isolated cases," *The Journal* article said, "there is every reason to believe that the mortality rate of 6 to 10 per cent in civilian hospitals with the sulfonamides may be significantly reduced by penicillin."

In studies to determine the smallest amount of penicillin that could be used effectively in the treatment of pneumonia, the doctors found that 10,000 units injected into the muscle four times daily for three days produced cures in every instance, but with smaller doses there were relapses and failures to respond to treatment.

NEW STUDY SHELVES OLD THEORY THAT DYES CAUSE SKIN TROUBLE

Physicians Find That In Most Instances Dermatitis Caused By Finishes Which Give Fabrics Better Appearance

Many people, especially women, believe that painful and itching skin irritations which they sometimes suffer are caused by dyes in wearing apparel. But two physicians, writing in the August 25 issue of *The Journal of the American Medical Association*, state that dermatitis or skin inflammation due to fabric dyes is relatively infrequent today.

"It has been shown that in most instances the dermatitis was caused by the finishes rather than by the dyes," the doctors report. Finishes are placed in fabrics to give them a better appearance such as luster, better feel and wearing properties, to prevent runs and unraveling, and to make fabrics nonecreasing, waterproof, mothproof, flameproof and moldproof.

The doctors who report their study in *The*

(*Continued on page* 70)

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Improved

Actual Therapy VS Prophylaxis

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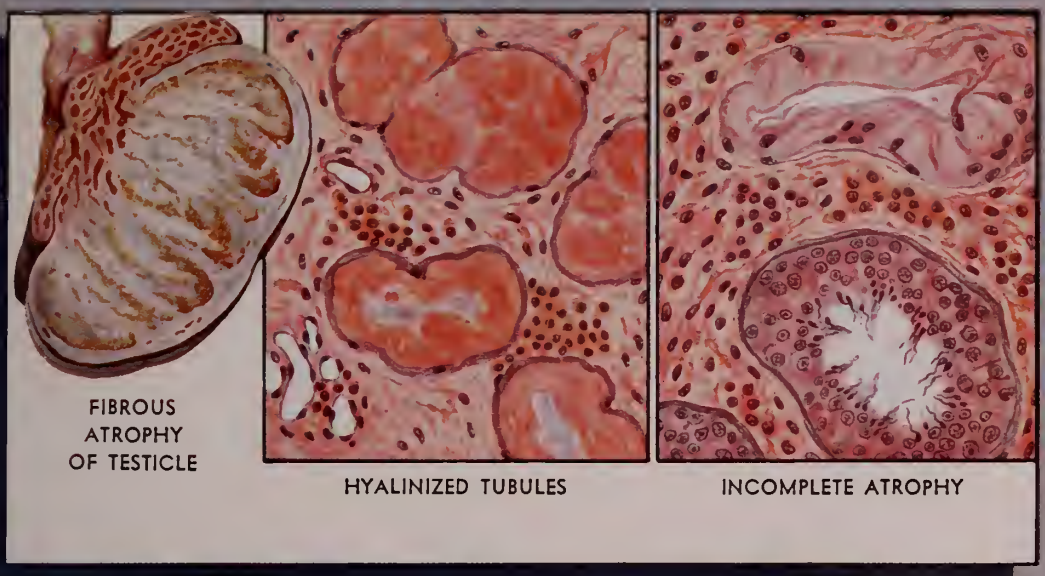
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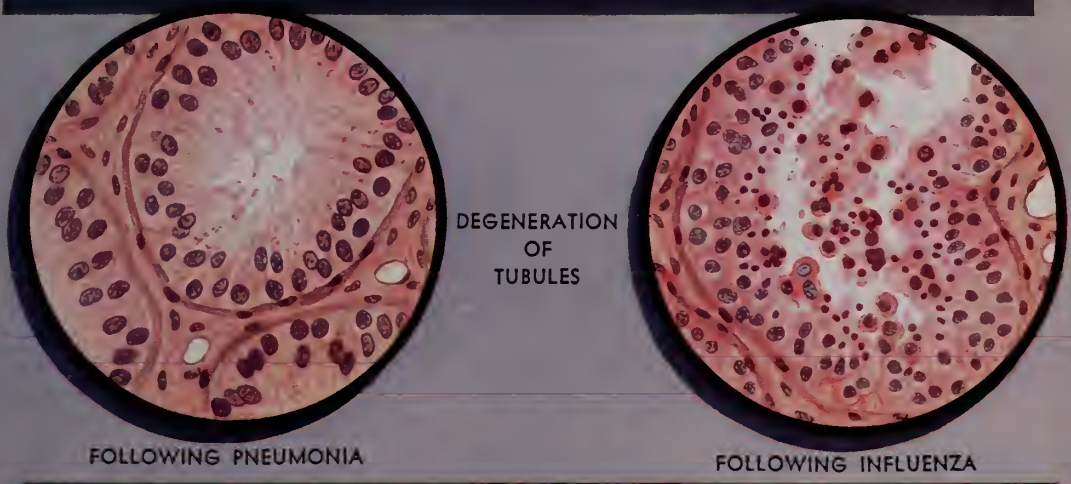
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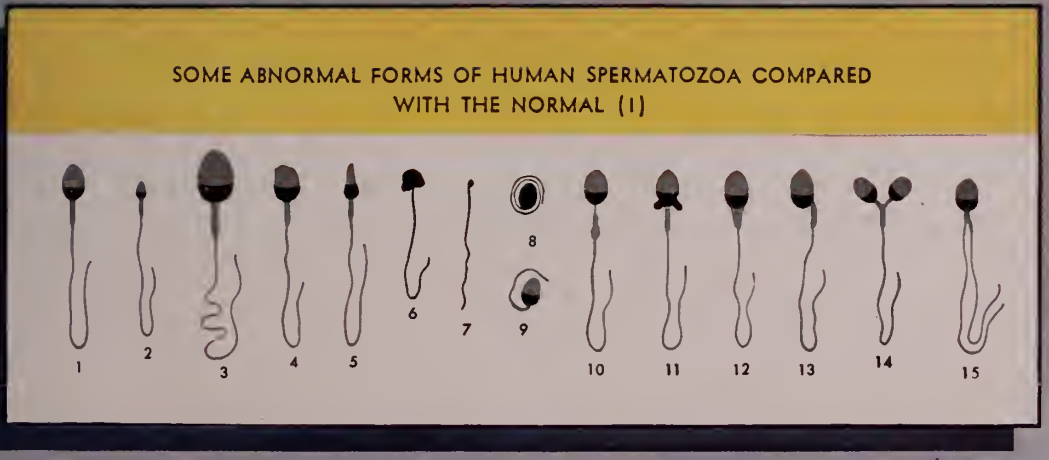
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F. Netter M.D.

STERILITY . . . from the Portfolio, "Major Pathology of Testicle and Prostate."

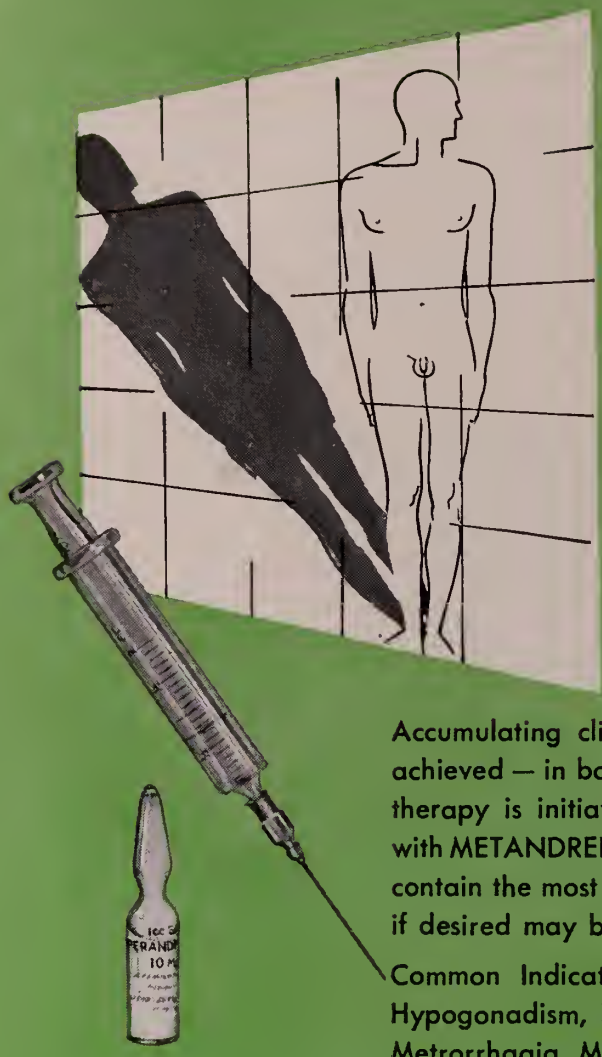
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NEW STUDY SHELVES OLD THEORY THAT DYES CAUSE SKIN TROUBLE

(Continued)

Journal are Louis Schwartz, Medical Director, and Samuel M. Peck, Senior Surgeon (Retired), both of the U. S. Public Health Service, Bethesda, Md.

The two authors point out that "when dermatitis is caused by the dyes, it is usually due to an idiosyncrasy to the dye itself or to a faulty process of dyeing, so that there is retained in the fabric some chemical which should not have been present. On occasion, dyes will cause dermatitis if one of the known sensitizing dyes is used. When dyes themselves have been found to be the cause of the dermatitis it has been usually found that they easily come out of the fabric or 'bleed.' Conditions on the skin surface may help to determine the 'bleeding' of the dyes from the fabric. For instance some will bleed out in acid perspiration and others in alkaline. Since some of the dyes are soluable in fat solvents, a high fat content on the skin surface may help dissolve them out."

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STRICT SANITARY CONDITIONS CAN END DYE POISONING AMONG BABIES

Many cases of dye poisoning, especially among babies, can be prevented, say four New Orleans investigators, by strict sanitary measures in the handling of all supplies entering the nursery. Julian Graubarth, M.D., Charles James Bloom, M.D., Francis Carter Coleman, M.D., and Harry N. Solomon, B.S., in their report in the August 18 issue of *The Journal of the American Medical Association,* review several cases of cyanosis—a dark coloring of the blood and tissues — caused by diapers stamped with an aniline dye.

Aniline is an oily, poisonous liquid, colorless when pure, which is the basis of many dyes. When aniline intoxication occurs in the body, chemical changes take place in the coloring matter of the red blood cells which render them incapable of transporting the normal amounts of oxygen. The grayish blue color which aniline intoxication imparts to the skin is considered a specific symptom. *The Journal* article explains that aniline has a direct and toxic effect on the nervous system. This is evidenced by such nervous symptoms as convulsions, involuntary trembling, dizziness, ringing in the ears and later paralysis — signs which are not easily detectable in young infants. There is also nausea, vomiting, abdominal pain and diarrhea.

"Because of the rarity of aniline dye intoxication in nurseries," the article points out, "the diagnosis is

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seldom thought of when exteremely pronounced and unexpected cyanosis appears." Cyanosis in the newborn or young baby may often resemble a condition caused by certain heart malformations which are present at birth. Two of the commonest causes of cyanosis encountered in the infant are pneumonia and the aspiration or breathing in of a foreign substance such as milk curds, mucus or mechanical objects.

The article states that "the treatment lies first in the prevention, then in removing the source." The authors caution that only small portions of aniline dye are necessary to produce intoxication in infants, and this is true also for adults. If diapers bearing the ink stamp with aniline dye are laundered before using, the dye is rendered harmless.

TUBERCULOSIS AND TOBACCO

"Statistical studies have not shown tuberculous infection or disease to be more frequent in users of tobacco than in those who abstain," says *The Journal of the American Medical Association* for August 11. *The Journal* adds that among tuberculous patients it has been found that those who smoke are apt to have a higher incidence of throat involvement and that such complications appear to be adversely affected by persistence in smoking. Most physiologists are convinced that, for the tuberculous patient, smoking can do no good and may do harm.

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SURGERY FOR THE AGED SHOULD NOT BE VIEWED WITH ALARM

Surgery for the aged —increasing in importance today — should not be considered with fear or alarm by patient and family, urges Louis Carp, M.D., in the August issue of *Hygeia, The Health Magazine.*

Dr. Carp, a New York City surgeon, points out that the increasing span of human life is offering a greater challenge to doctors. Based on the latest census figures, there was an increase of 35 per cent of persons over 65 years of age between 1930 and 1940. In another 15 years, life expectancy should reach 75 years. Consequently, the health, social, economic and political significance of the increase of life span must be emphasized.

"Old age does not necessarily prevent surgical procedures," Dr. Carp remarks, "which may save or prolong life, produce continued physical comfort and the relief of pain, and add economic, functional and social usefulness. Today there are still many instances of a defeatist attitude toward surgery for the aged on the part of both patient and family alike. These outdated attitudes should be abandoned in favor of a more progressive outlook, the result of marvelous advances in medicine and surgery in the past quarter century. It should be our aim to 'add life to years and years to life.'"

"Modern methods and scientific advances," the surgeon explains, "especially in chemistry and refinements of technique and anesthesia, have so improved surgical standards that it is essential for old people afflicted with a surgical condition, and also their families and friends, to adopt a more hopeful and favorable attitude toward surgical results and to consider that what appears to be a radical step may turn out to be conservative after the operation. One of the purposes of medical preparedness is to improve the health of our civilian population. This calls for cooperation on the part of the aged, and when a surgical condition gives rise to a menace to life, incapacity and dislocation from everyday economic, functional and social routine, surgical treatment will produce cure or improvement so often that the patient can go on with a happier, healthier life and a more hopeful and more optimistic perspective."

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October, 1945

In This Issue

Global Disease

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Public Assistance For The Blind in Illinois

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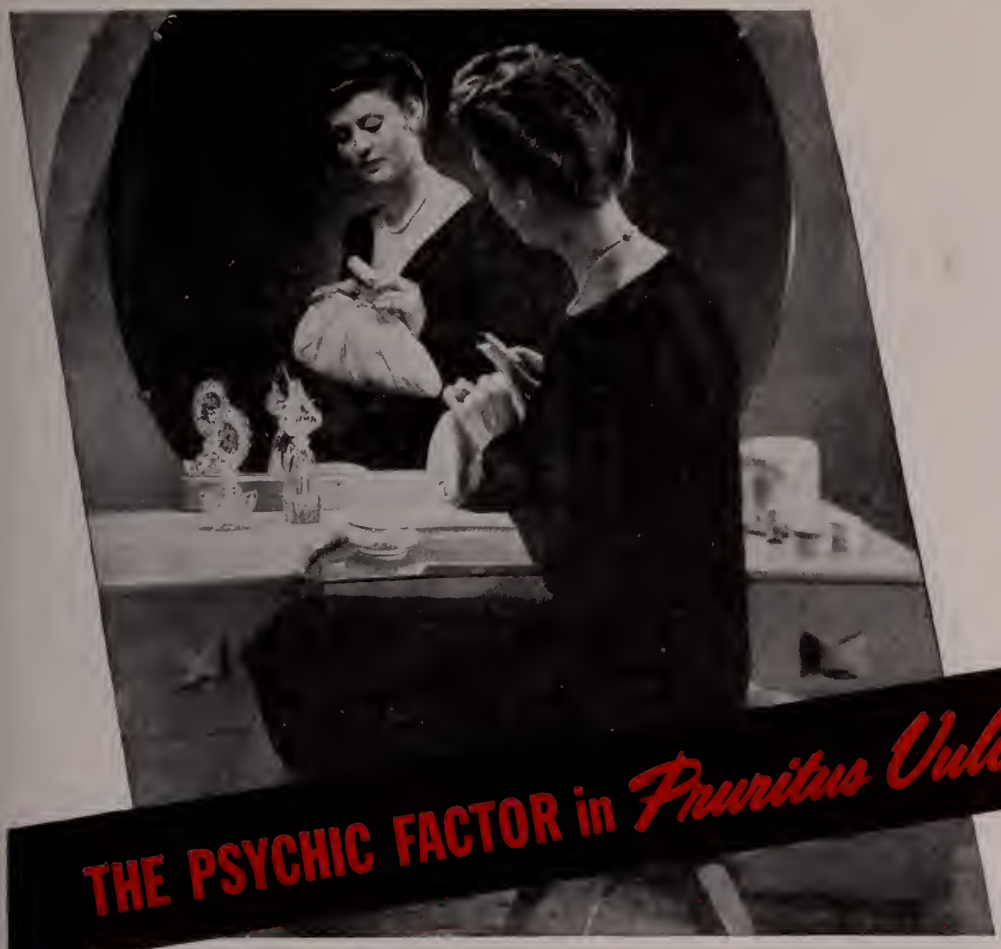
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Haman, J. O.: Am. J. Obst. & Gynec. 47: 686 (May), 1944.

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[1] Cohen, A., and Dubbs, A. W.: New England J. Med. 229:773, 1943.

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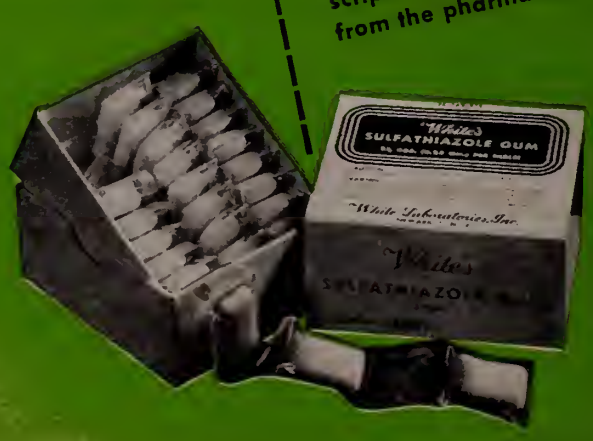
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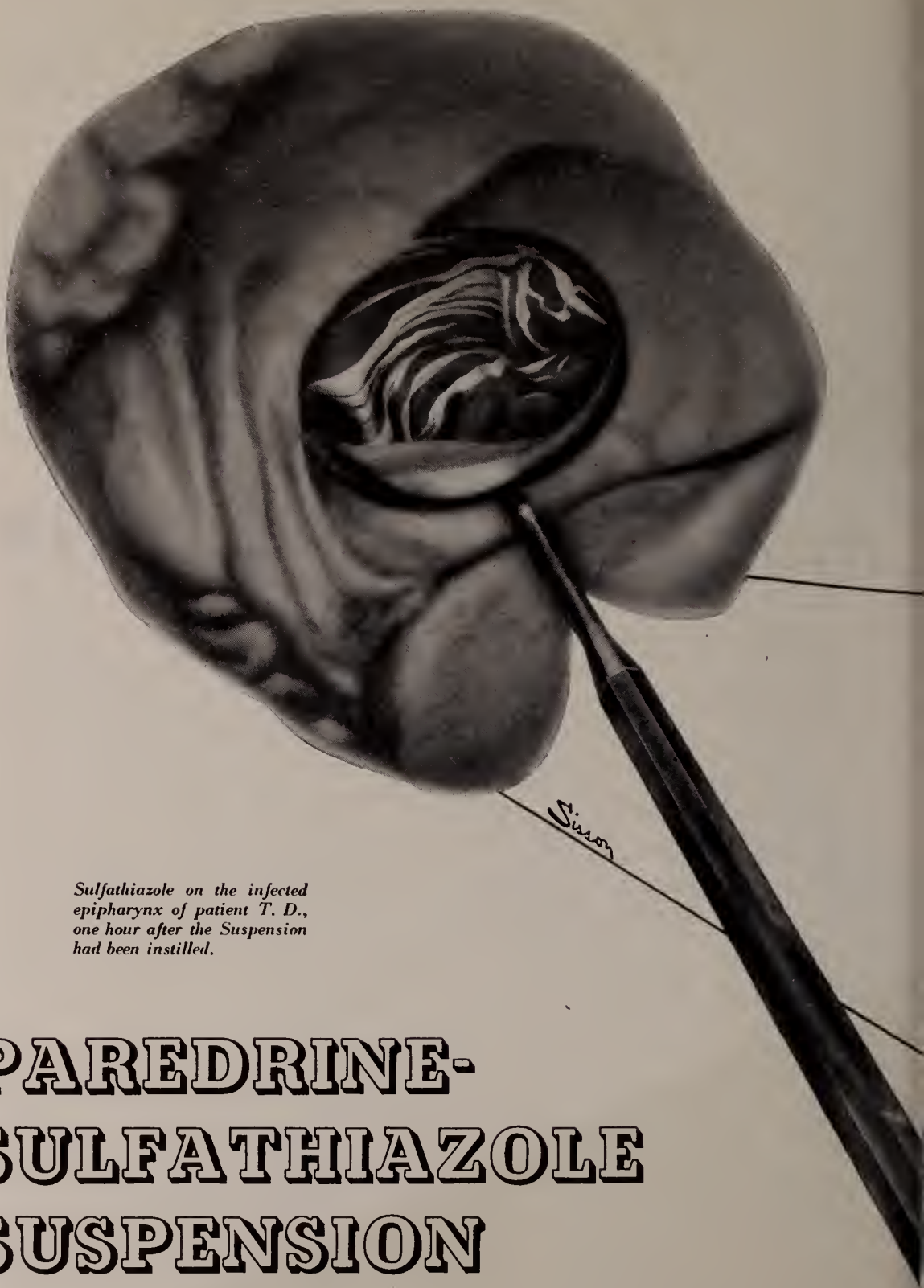
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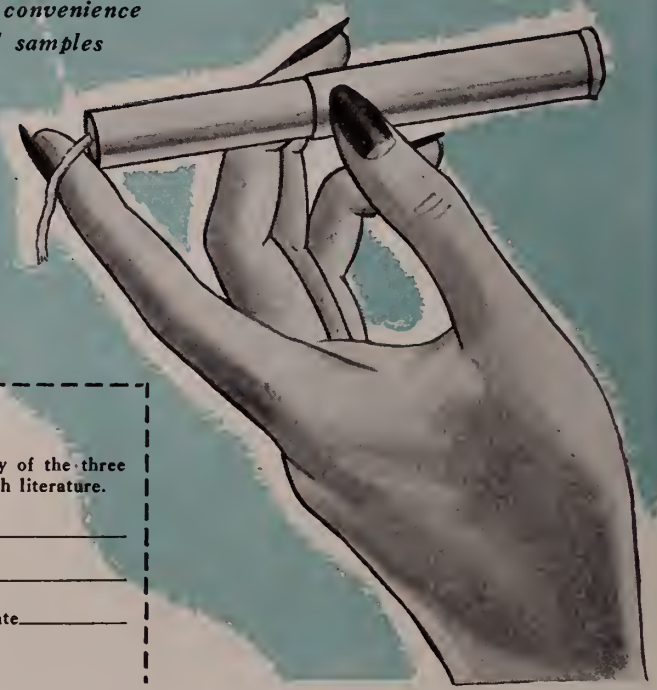
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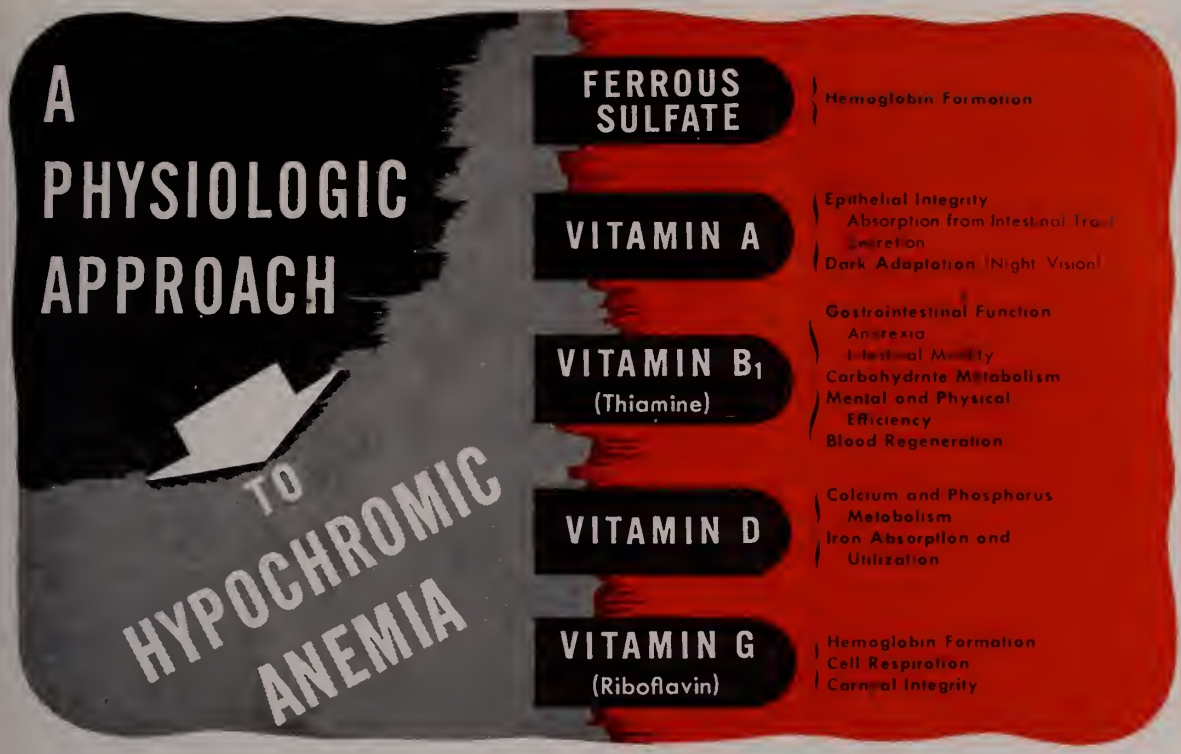
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Physiologic impairment in hypochromic anemia slowly induces a decline in certain phases of metabolic activity and impoverishes cell nutrition. Though the reduction in hemoglobin is readily detectable, its effects on the organism as a whole may become well established before discerned.

Anorexia is but one example, and accounts for an inadequate intake of essential nutrients. Even this inadequate intake may not be fully utilized because of anemia-engendered hypochlorhydria. Hence restoration of iron reserves is hampered.

Treatment therefore needs to be directed not only at the iron deficiency, but at the impaired functional activities as well. To this end, Heptuna provides an effective combination of readily available iron—adequate for the restoration of a plentiful reserve—and, in addition, significant amounts of vitamins A and D, and the B complex group (partly derived from a vitamin-rich liver extract and yeast).

J. B. ROERIG & COMPANY, 536 Lake Shore Drive • Chicago 11, Illinois



Each Capsule Contains:

FERROUS SULFATE	4.5 gr.
VITAMIN A	5000 U.S.P. Units
VITAMIN B_1 (1 mg.)	333 U.S.P. Units
VITAMIN D	500 U.S.P. Units
VITAMIN G (0.50 mg.)	500 micrograms

together with liver concentrate (vitamin fraction), derived from 4 grams of fresh liver, and dried brewers' yeast.

Heptuna

a ROERIG *Preparation*

Wyeth
REG. U.S. PAT. OFF.

*". . . FIRST IN THE CHOICE OF DIGITALIS MATERIALS"**

PURODIGIN

REG. U.S. PAT. OFF.

➡ COMPLETELY ABSORBED BY MOUTH

➡ PERMITS PRECISE DOSAGE

PURODIGIN permits precise dosage based on weight, eliminating the uncertainty of doses based on different *units*.

DIGITOXIN is the only digitalis material known to be completely absorbed when given by mouth.

WYETH developed Purodigin to satisfy the need for a uniform, potent digitalis product for rapid digitalization by oral administration.

*Gold et al., J. Pharmacol. 82:187, 1944.

Supplied in vials of 30 scored tablets and bottles of 100, 0.2 mg. each



PURODIGIN

(DIGITOXIN)

Wyeth

WYETH INCORPORATED • PHILADELPHIA 3 • PA.



Council Acceptance for

STAPHYLOCOCCUS TOXOID

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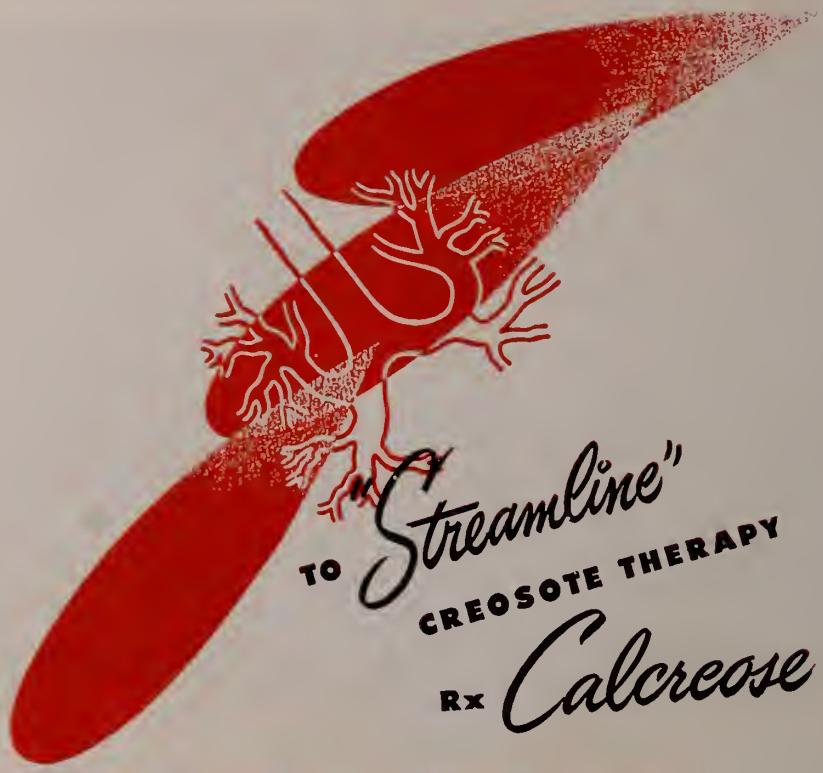
The use of a protein-free culture medium in the preparation of this new and improved Staphylococcus Toxoid reduces, to a minimum, both allergenic and local reactions...but at no sacrifice of its high antigenicity.

Prepared and biologically standardized under the supervision of Professor E G D Murray and supplied with the approval of the Department of Bacteriology and Immunity, McGill University

Available in 3 cc. rubber-capped vials

AYERST, McKENNA & HARRISON LTD... *Biological and Pharmaceutical Chemists*

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"Streamline" TO CREOSOTE THERAPY

Rx Calcreose

PALATABLE • WELL TOLERATED • THERAPEUTICALLY EFFECTIVE

The development of CALCREOSE (Maltbie) has, indeed, "smoothed the rough spots" in creosote therapy so frequently provocative heretofore of nausea and distress. • Moreover, CALCREOSE (calcium creosotate) exerts bactericidal and bacteriostatic action up to *three times as great* as that of creosote. • Thus, in providing all the well-known benefits of creosote in a *pleasant* and *palatable* form, CALCREOSE proves highly effective in many bronchial and respiratory affections . . . lessening cough, diminishing expectoration, reducing its purulency and deodorizing sputum. Also it tends to stimulate the appetite and improve the patient's general condition.

AVAILABLE: As tablets (4 gr.) in bottles of 100, 500, and 1000. COMPOUND SYRUP CALCREOSE in pint or gallon bottles.



Calcreose

THE MALTBIE CHEMICAL COMPANY • NEWARK, NEW JERSEY

EFFECTIVE TOPICAL CHEMOTHERAPY IN COMMON OTOLOGIC INFECTIONS

White's OTOMIDE

Both *acute* and *chronic* suppurative and nonsuppurative infections of the middle and external ear respond to the well-balanced formula of White's Otomide.

FORMULA

Sulfanilamide	5%
Carbamide (urea)	10%
Chlorobutanol (compatible with sulfonamide	3%
Glycerin (High specific gravity)	q.s.

RATIONALE AND ADVANTAGES

1. *Wide Field*—effective in *BOTH* acute *AND* chronic otologic infections.
2. *Well Tolerated*—physiologic pH—hence free from irritation.
3. *High Stability*—a *stable* sulfonamide-urea solution.
4. *Antibacterial Potency with Analgesia*—effective chlorobutanol analgesia *without* impaired sulfonamide activity.
5. *Hygroscopic*—glycerin vehicle re-distilled for unusual hygroscopic activity.

White's Otomide is available in dropper bottles of one-half fluid ounce (15 cc.)—*on prescription only.*



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THE VITAMINS A and D OF COD LIVER OIL STILL AVAILABLE — *with Marked Economy*

The preference of so many physicians for the *natural* A and D vitamins is not surprising in view of the widespread use of cod liver oil as *the* source of these essential nutrients.

White's COD LIVER OIL CONCENTRATE

provides the *natural* vitamins A and D derived exclusively from cod liver oil and free from excess bulk and fatty oils.

Dosage forms suited to every type of patient afford maximal convenience of administration. *DROP DOSAGE* for infants and young children; *TABLETS* (which may be chewed) for growing children; *CAPSULES* for adult dosage as during pregnancy, lactation, convalescence and in old age.

ECONOMICAL — Prophylactic antirachitic dosage for infants costs less than one cent a day.

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When the Fetus Steals Maternal Iron

To guard against hypochromic anemia during pregnancy, Fergon is particularly valuable because it is exceptionally well tolerated. Fergon is virtually non-irritating therefore rarely associated with gastro-intestinal distress.

Fergon

Ferrous Gluconate Stearns

FOR HYPOCHROMIC ANEMIAS

COMPOSITION: Fergon is *improved* ferrous gluconate. Prepared and stabilized by Stearns' special process, it contains no more than 0.2% ferric iron.

THERAPEUTIC APPRAISAL: Fergon, being only slightly ionized, is virtually non-astringent, non-irritating; thus it may, and should, be administered before meals to facilitate maximum absorption ... Readily soluble and available for absorption throughout the entire pH range of the gastro-intestinal tract ... Published data show that ferrous gluconate is more efficiently utilized than other iron salts.*



INDICATED in the treatment and prevention of anemias due to iron deficiency; especially valuable in patients who do not tolerate other forms of iron.

DOSAGE: Average dose for adults is 3 to 6 tablets (5 gr.) or 4 to 8 teaspoonfuls of elixir daily: for children, 1 to 4 tablets (2½ gr.) or 1 to 4 teaspoonfuls elixir daily.

SUPPLIED as 5% elixir, bottles of 6 and 16 fl. oz.; 2½ gr. tablets, bottles of 100; 5 gr. tablets, bottles of 100, 500 and 1000.

*Reznikoff, P., & Goebel, W. F., J. Clin. Investigation, 16:547; 1937

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FOR VACCINE THERAPY *of* BRUCELLOSIS (UNDULANT FEVER)



To meet the needs of the clinician who is called upon to treat the various types of Brucellosis, Pitman-Moore Biological Laboratories offer—

UNDULANT FEVER VACCINE
(MELITENSIS)
(Bio. No. 60)
Brucella melitensis . . 2000 million per cc.

UNDULANT FEVER VACCINE
(ABORTUS and SUIS)
(Bio. No. 62)
Brucella abortus 1000 million per cc.
Brucella suis 1000 million per cc.

Both vaccines available in 6 cc. and 20 cc. vials.

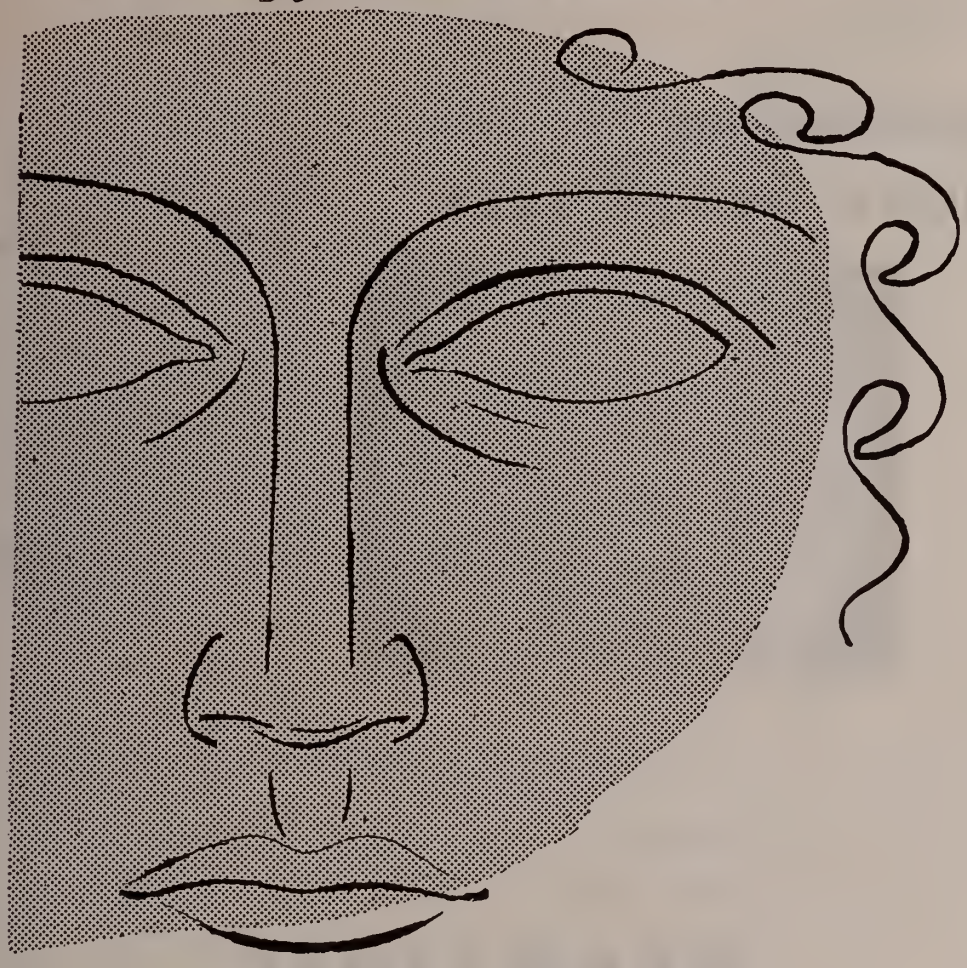
Selection of *Type* of Vaccine

Since no one clinical test has as yet been devised to differentiate between the several strains which may be involved, the selection of vaccine must depend upon the history of the case. Since most cases are identified with either the bovine or porcine species of organism, it is customary in practice to use a bi-valent vaccine containing these two organisms, except where the caprine organism can be reasonably incriminated.

Literature on request

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PHARMACEUTICAL AND BIOLOGICAL CHEMISTS
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Fewer Coryza Complications



When you prescribe Sulmefrin, the danger of sinusitis and other complications is lessened. A few drops make breathing easier —make for a more comfortable patient. Sulmefrin relieves congestion through the vaso-constrictor action of *dl*-desoxyephedrine hydrochloride (0.125%)—and combines the antibacterial properties of sodium sulfathiazole (2.5%). Mildly alkaline, Sulmefrin is non-irritating, helps to dissolve mucous and mucopurulent secretions, and does not impede ciliary action. Administered by spray, drops or tamponage.

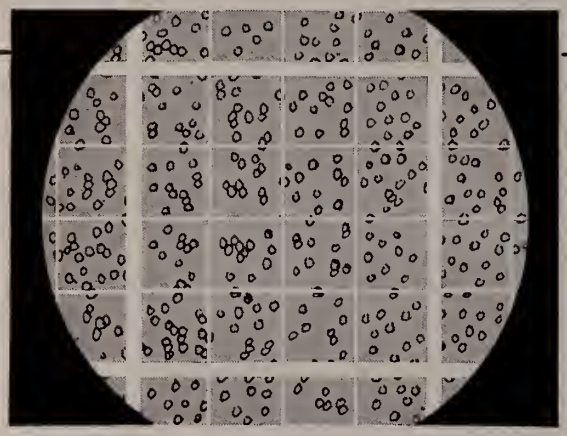
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MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

Number 3 of a Series

IN ANEMIA OF CHRONIC BLOOD LOSS





In the management of chronic blood loss, therapy designed to support red cell and hemoglobin formation is essential. Iron must be supplied to correct hypochromia; liver and the B vitamins bolster an overworked bone marrow in the production of red cells. The combination is more effective than iron alone.

HEPATINIC

presents iron in readily assimilable ferrous form, together with Crude (Unfractionated) Liver Concentrate and Vitamin B Complex.

Crude (Unfractionated) Liver Concentrate is prepared so that it retains the erythropoietic and nutritional principles of whole liver, which are lost in the highly refined concentrates. Furthermore, it is subjected to enzymatic digestion to provide maximum assimilation and prompt therapeutic response.

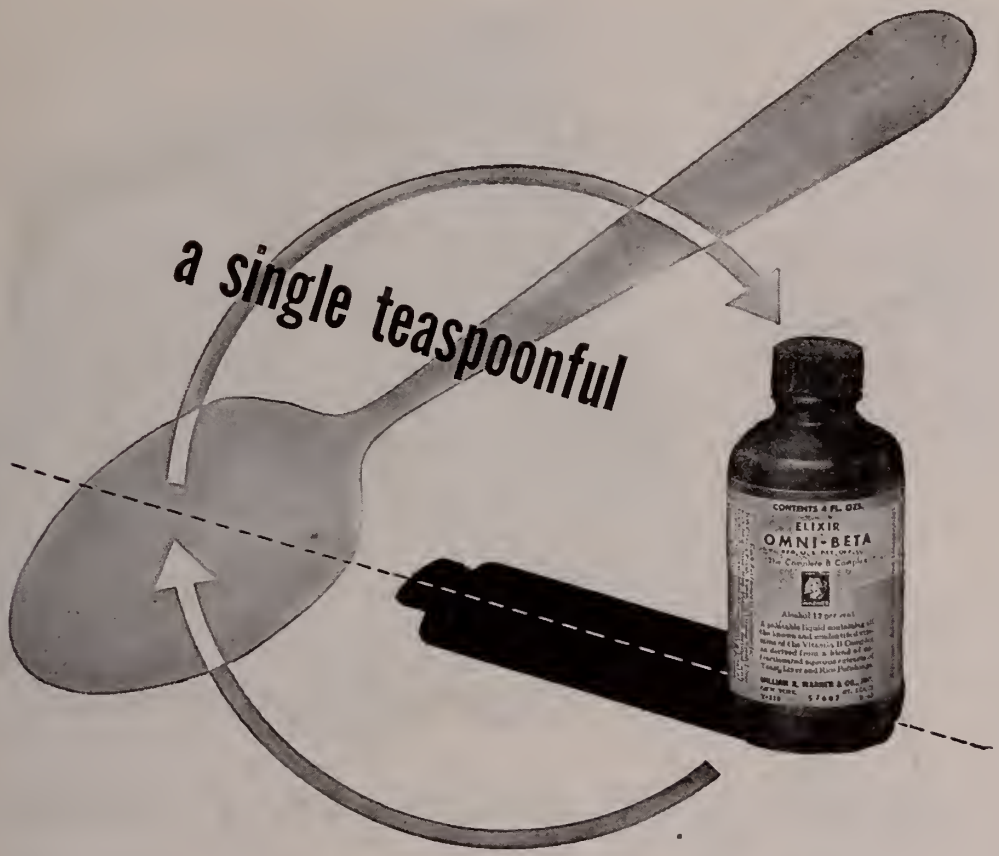
The appealing and palatable taste of Hepatinic assures patient acceptance and particularly recommends the product for pediatrics.

FORMULA: Each fluidounce Elixir Hepatinic contains:

Ferrous Sulfate 12 gr., Crude (Unfractionated) Liver Concentrate (equivalent to 660 gr. fresh liver) 60 gr. Thiamine Hydrochloride 2 mg., Riboflavin 4 mg., Niacinamide 20 mg., together with pyridoxine, pantothenic acid, choline, folic acid, vitamin B_{10}, vitamin B_{11}, biotin, inositol, para-amino-benzoic acid, and other factors of the vitamin B complex.

Bottles of one pint and one gallon. Tasting samples on request.

McNeil Laboratories
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Providing the minimum adult daily requirements of all the essential B-vitamins in a single teaspoonful, Elixir 'Omni-Beta'* assures full-range balanced replacement of every known as well as all unidentified factors present in three of the richest *natural* sources . . . liver, yeast, and rice polishings.

Highly concentrated in a *palatable* liquid medium, Elixir 'Omni-Beta' offers exceptional efficacy enhanced by simplified administration.

a single teaspoonful contains:

- *as much* Thiamine *as* **25 tablets brewers' yeast (7½ gr.),**
- *as much* Riboflavin *as* **100 tablets brewers' yeast (7½ gr.) and**
- *as much* Niacinamide *as* **66 tablets brewers' yeast (7½ gr.);**

plus pantothenic acid, pyridoxine, and all other B-complex factors. Aqueous extract 2.594 Gm. per teaspoonful, concentrated from 13 Gm. yeast, 7 Gm. liver and 7 Gm. rice polishings.

In bottles of 4 and 8 fluidounces.

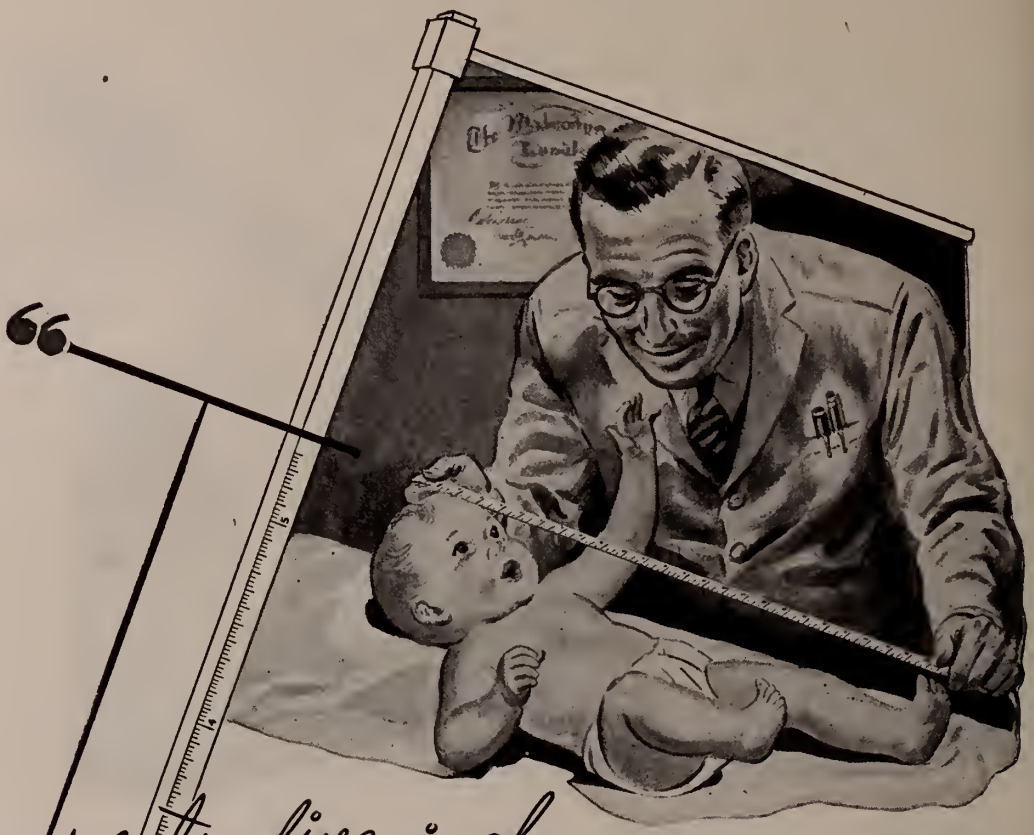
WILLIAM R. WARNER & CO., 113 WEST 18TH STREET, NEW YORK 11, N. Y.

OMNIS ORBIS WARNER

*Reg. U.S. Pat. Off.

'ELIXIR omni-beta'

VITAMIN B-COMPLEX



"Twenty-five inches—THAT'S GOOD!"

Easily calculated . . . quickly prepared. 1 fl. oz. Biolac to 1½ fl. oz. water per pound of body weight.

Healthy, happy babies are indeed a familiar sight to physicians prescribing Biolac. For Biolac is a *scientifically formulated infant formula*—specifically designed for the normal infant. Its high protein level contributes to optimal growth and general well being . . . ample lactose assures soft, natural stools and no carbohydrate supplementation is required. Its adjusted milk fat content and soft curd characteristics provide ease of digestion and assimilation. Biolac provides for *complete nutritional requirements,* when supplemented with vitamin C, throughout the entire bottle period—with freedom from time-consuming formula calculations.

BORDEN'S PRESCRIPTION PRODUCTS DIVISION
350 MADISON AVENUE . . . NEW YORK 17, N. Y.



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"BABY TALK" FOR A GOOD SQUARE MEAL

Biolac is a liquid modified milk, prepared from whole and skim milk, with added lactose, and fortified with vitamin B_1, concentrate of vitamins A and D from cod liver oil, and iron citrate. Evaporated, homogenized, and sterilized. Biolac is available in 13 fl. oz. cans at all drug stores.

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NEW BORN



CHILD



NORMAL CYCLICAL FEMALE



PREGNANCY (Advanced)



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VAGINAL MUCOSA...

from the Portfolio, "Endocrine Physiology in the Female."

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TOMORROW'S MEDICINES FROM TODAY'S RESEARCH



Alexandre Danné, discoverer of the organism—
Trichamanas vaginatis, 1836.

Effective Vaginitis Therapy
WITH
VIOFORM INSERTS



Vioform, well-established as a trichomonacide, is now also available as VIOFORM INSERTS*, containing Vioform, boric acid and lactic acid.

VIOFORM INSERTS used in office routine—and for supplementary home treatment—hasten the prompt eradication of the parasites of trichomonas vaginitis, as well as the disappearance of the discharge. They aid in restoring normal acidity, meanwhile acting as an effective deodorant.

Vioform Inserts Issued in packages of 15

*Trade Mark Reg. U. S. Pat. Off. Word "Vioform" identifies the product as iodochlorhydroxyquinoline of Cibo's manufacture. Each "Insert" contains 250 mg. Vioform, 25 mg. lactic acid and 100 mg. boric acid.

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REMEMBER—
Ung-CAL
for
ITCHING!
Calamine, zinc oxide and benzocaine in a specially developed greaseless cream base.
RELIEVES ITCHING PROMPTLY . . .
PROTECTS . . . AIDS HEALING
Use in pruritus ani, vulvae and scroti — eczema — intertrigo — chafing — diaper rash — rashes of exanthems — plant dermatitis — and other irritative skin conditions.
In 2 oz. tubes and 1 lb. jars.
Literature and sample from Crookes Laboratories, Inc., 305 East 45th Street, N. Y. 17, N. Y.
CROOKES



This, too, will be written in history

Among the many brilliant originations, the inspired improvisations, of the Medical Corps in World War II was the use of the "ambulance on wings."

When the photograph above was taken, the casualties lined up had *just been wounded!* Already they had been given emergency medical aid, and in a matter of *minutes* were on their way to a base hospital with complete facilities far away from the combat zone . . . Thanks to such immediate surgical care, quick hospitalization, and all the companion advancements of wartime medical science, 97 out of every 100 such casualties *lived!*

Thanks should be proffered most generously to the incredible diligence of those "soldiers in white" who created and tirelessly practiced these techniques—the medical men in the service whose rest all too often was no more than a moment and a cigarette. Incidentally, that cigarette was very likely a Camel, an especial favorite of all fighting men.

R. J. Reynolds Tobacco Company, Winston-Salem, North Carolina



Camels

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A More Convenient Form of Therapy

When luteal hormone therapy is needed, Progestoral (anhydro-hydroxy-progesterone 'Roche-Organon'), the orally effective form of the luteal hormone, is the choice of many physicians, for "anhydrohydroxyprogesterone offers a more convenient form of therapy."* By prescribing Progestoral, you assure your patient of potent luteal therapy without the inconvenience of frequent injections and at a considerably lower cost. Progestoral therapy is of value in functional uterine bleeding, premenstrual tension, functional dysmenorrhea, and spontaneous abortion. For your prescription, Progestoral is available in 5-mg and 10-mg tablets, boxes of 20, 40, 100, and 250.

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PROGESTORAL *'Roche-Organon'*

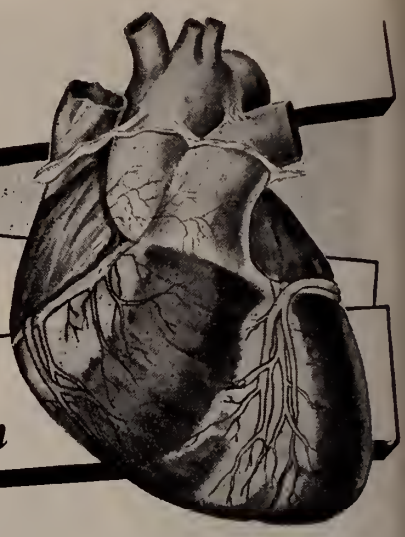
(anhydro-hydroxy-progesterone)

*J. K. Quigley, *Am. J. Obst. & Gynec.*, 49:633, 1945

The chief active glycoside of Digitalis purpurea...

as effective by mouth as by vein...

virtually free from nausea and vomiting due to local action



DIGITALINE NATIVELLE, the original, pioneer digitoxin, the chief active glycoside of Digitalis purpurea in pure, crystalline form, brings to digitalis therapy a notable efficacy and simplicity of dosage. It permits of effective, rapid, single-dose oral digitalization within 3 to 6 hours, with an "average dose" that almost never leads to nausea or vomiting from local irritant action.

NOTE THESE ADVANTAGES

1—*Potency:* Since it is the chief active glycoside of Digitalis purpurea, Digitaline Nativelle literally is digitalis freed from the inert material which in digitalis leaf preparations clings to the active substance.

Hence, weight for weight it is 1000 times as potent as U.S.P. XII digitalis when given orally, *one milligram* exerting approximately the same action as *one gram* of whole-leaf digitalis. This potency is constant, permitting of precise dosage by weight, instead of bio-assay "units."

2—*Absorption:* Digitaline Nativelle is absorbed quantitatively, probably directly from the stomach. Dosage is therefore the same whether given by mouth or by vein.

3—*Speedy Action:* There is no demonstrable difference in the speed with which its full action is exerted, whether it is administered orally or intravenously.

4—*Less Local Irritation:* The dosage required for initial digitalization is so small that nausea and vomiting from local irritant action are almost never encountered.

ACTION AND INDICATIONS

Since Digitaline Nativelle is the chief active glycoside of Digitalis purpurea, its action is that of digitalis. Hence it is indicated whenever digitalis is called for.

SINGLE-DOSE DIGITALIZATION

In urgent cases, it is recommended that the entire oral digitalizing dose —1.2 mg., established as "average" in more than a thousand consecutive unselected cases—be given at one time. Its full effect will be produced in 3 to 6 hours. In other cases, if preferred, this dosage may be given in divided amounts, over 12 to 24 hours.

MAINTENANCE

It is recommended that maintenance be instituted with 0.1 mg. (equivalent to 1½ gr. of digitalis leaf) daily, and increased if and as required.

Available on prescription through all pharmacies.

Digitaline Nativelle is reasonably priced, within reach of every patient.



Physicians are invited to send for samples, literature, and bibliography.

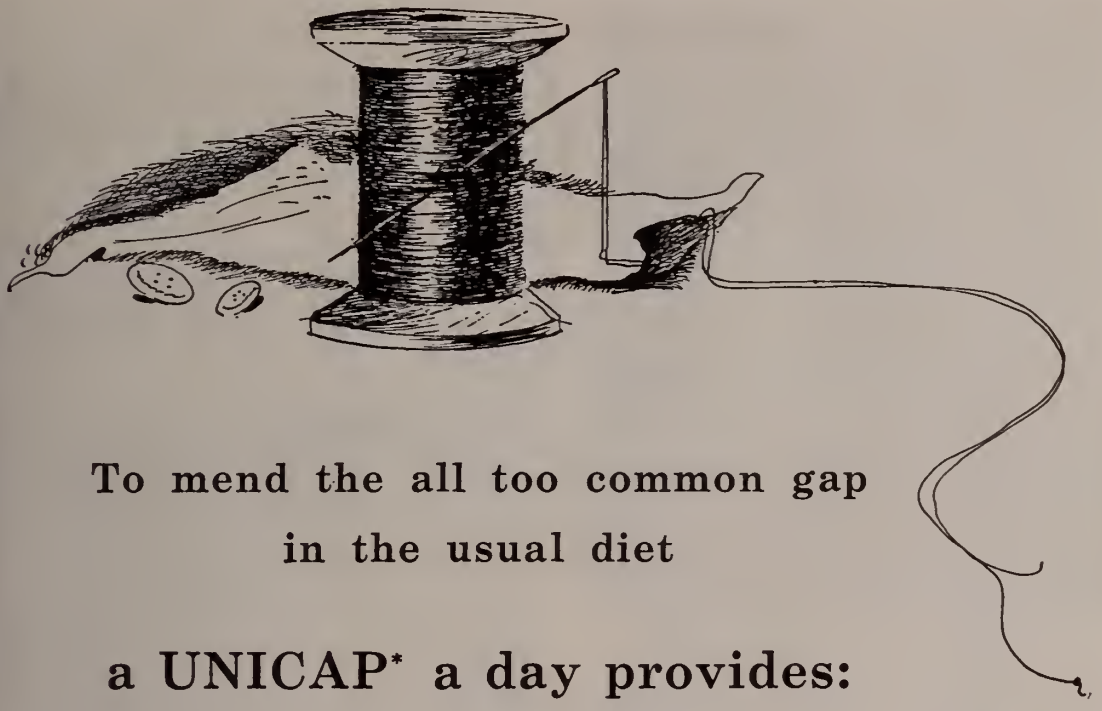
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A Division of E. Fougera & Co., Inc.
75 Varick Street, New York 13, N. Y.

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COUNCIL ACCEPTED

Digitaline Nativelle

REG. U. S. PAT. OFF.

THE ORIGINAL DIGITOXIN, IN PURE CRYSTALLINE FORM



To mend the all too common gap in the usual diet

a UNICAP* a day provides:

Vitamin A	5000 U.S.P. units
Vitamin D	500 U.S.P. units
Ascorbic Acid (Vitamin C)	37.5 mg.
Thiamine Hydrochloride (Vitamin B_1)	1.5 mg.
Riboflavin (Vitamin B_2, G)	2.0 mg.
Pyridoxine Hydrochloride (Vitamin B_6)	0.2 mg.
Calcium Pantothenate	1.0 mg.
Nicotinic Acid Amide (Nicotinamide)	20.0 mg.

AVAILABLE IN BOTTLES OF 24, 100, AND 250

*Trademark, Reg. U. S. Pat. Off.

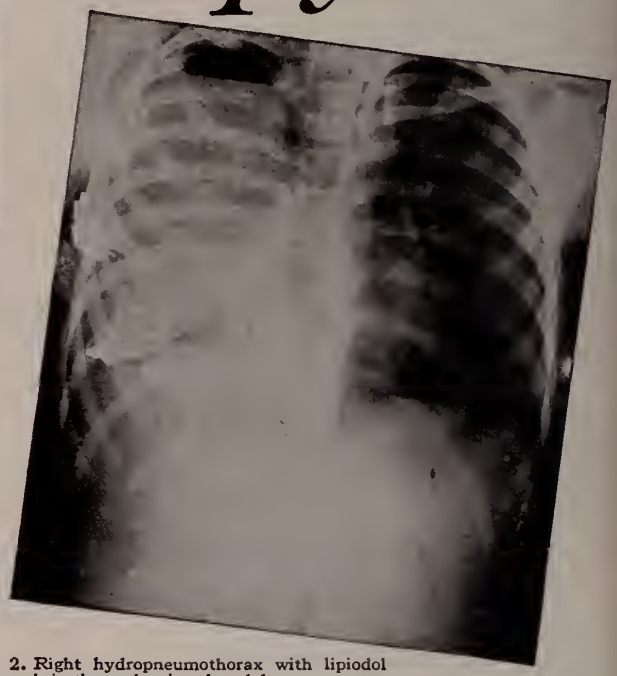
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1. Right lobar pneumonia (type 1) and right empyema.

Penicillin in Empyema



2. Right hydropneumothorax with lipiodol injections showing interlobar empyema.

3. After injecting Penicillin in saline into empyema cavity daily for five days.



Size of cavity, type of infection, and number of organisms determine the amount of penicillin to be administered in empyema. Usually 50,000 or 100,000 units in normal physiologic saline solution are injected once or twice daily directly into the empyema cavity after aspiration of pus or fluid. (Keefer, C. S.: New Dosage Forms of Penicillin, J.A.M.A. 128:1161 [Aug. 18] 1945.) Treatment is by instillation, rather than irrigation, because penicillin requires at least 6 to 8 hours of contact for maximum effect.

Bristol Penicillin, because of its freedom from toxicity and pyrogens, as well as absolute sterility and standard potency assures the desired pharmacologic action.

The rapidly developing new clinical uses of this potent antibiotic are abstracted in issues of the BRISTOL PENICILLIN DIGEST. If not receiving *your copies* regularly, write. Order Bristol Penicillin through your physicians' supply house.

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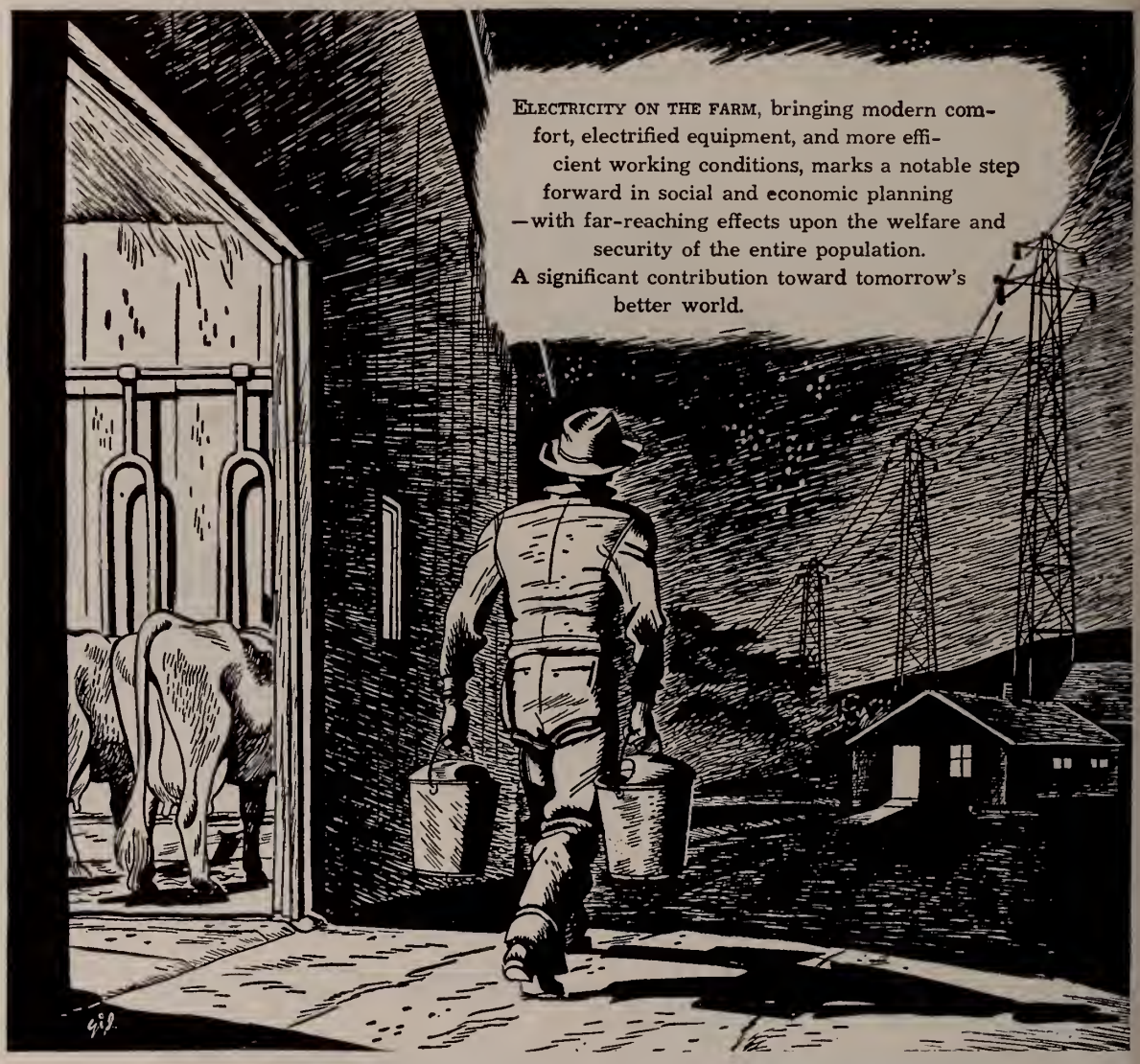


When patients are given Cal-C-Tose, the physician is assured of their cooperation because they actually enjoy taking vitamins in this palatable form. Either hot or cold, Cal-C-Tose makes a tempting beverage whose delicious chocolate flavor carries no suggestion of medication. Cal-C-Tose supplies generous amounts of vitamins A, B_1, B_2, C, and D, and dibasic calcium phosphate in a form acceptable even to fastidious patients. Available in 12-oz and 5-lb containers. . . .

HOFFMANN-LA ROCHE, INC. • ROCHE PARK • NUTLEY 10, NEW JERSEY

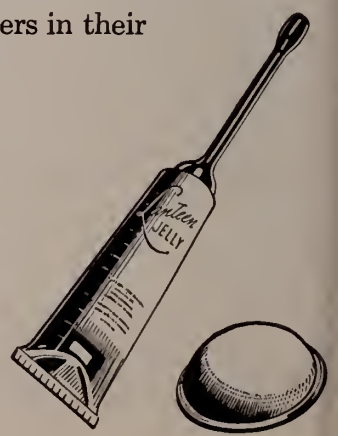
THE PLEASANT WAY TO TAKE VITAMINS **CAL-C-TOSE** *'Roche'*

Toward a Better World



LANTEEN MEDICAL LABORATORIES present another phase of forward planning toward sociological betterment—with Lanteen products, leaders in their field, produced under the most rigid scientific standards.

Since patients are not mechanically minded, simplicity and ease of handling are prime requisites for continued use. Lanteen Flat Spring Diaphragm is extremely simple to place—it is collapsible in one plane only. No inserter required. Distributed ethically—advertised only to the medical profession—available only upon the recommendation or prescription of a physician. Complete information upon request.



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PENICILLIN OINTMENT SCHENLEY



It is possible by topical application to reach local levels of penicillin activity far in excess of the highest ranges maintained by intravenous and intramuscular administration.

Penicillin Ointment Schenley is indicated in the treatment of superficial infections of the skin caused by penicillin-sensitive organisms. In deep-seated pyogenic infections with penicillin-sensitive organisms, the ointment may be used as an adjunct to systemic penicillin therapy and other measures.

When you specify Penicillin Ointment Schenley, you are assured of the highest standard of excellence, because Schenley Laboratories maintains the same rigid program of control for this ointment as it has always maintained for Penicillin Schenley.

SCHENLEY LABORATORIES, INC.
Executive Offices: 350 Fifth Avenue, New York City

FOR ASSURED ASSIMILATION
WARREN-TEED *Ri-Plex*

Parenteral B Complex Administration



● Proper assimilation and utilization of needed vitamin B complex is a problem often solved only by parenteral administration. Warren-Teed Ri-Plex is easy to administer (small volume dose); may be injected intravenously, subcutaneously, or intramuscularly; causes patient no appreciable discomfort. Ri-Plex frequently offers the solution to such conditions as:—

Nausea and Vomiting of Pregnancy



Latest reports indicate the greater effectiveness of mixed vitamin B factors.

Secondary Anemia



Contains several factors necessary to the assimilation of iron and regeneration of blood.

Chronic Gastro-Intestinal Malfunction



Eliminates all doubt of complete assimilation and utilization of B complex factors.

★

Each 2 cc. Ri-Plex Ampul contains:

Thiamine Hydrochloride 10 mg. — Riboflavin 4 mg. — Nicotinamide 150 mg. — Pyridoxine Hydrochloride 5 mg. In Isotonic Solution of Sodium Chloride. Supplied in 2 cc. ampuls in boxes of 12 and 25.

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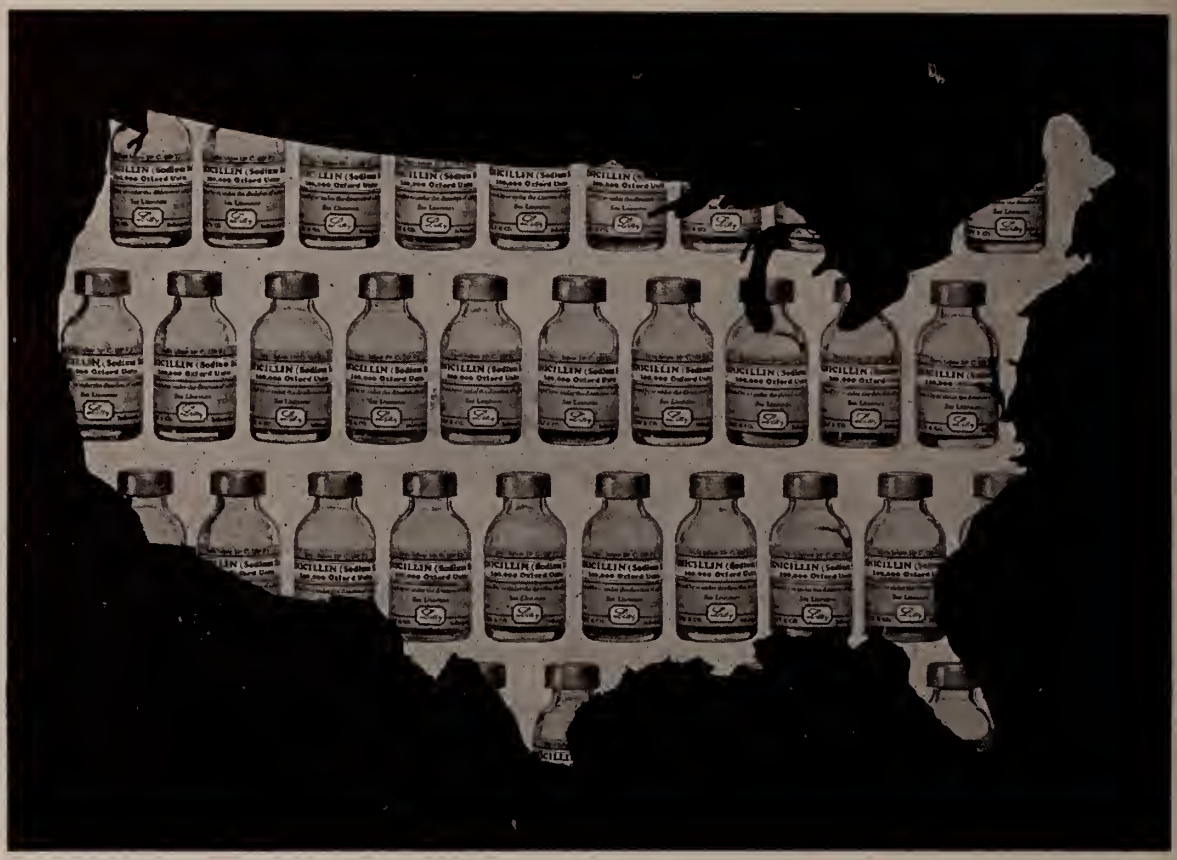
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October, 1945
VOL. 88, NO. 4

The Illinois Medical Journal

Official Journal of the Illinois State Medical Society

EDITOR — Harold M. Camp. EDITORIAL BOARD — James H. Hutton, Chairman, Frederick H. Falls, Josiah J. Moore, Edwin M. Miller, Chauncey C. Maher, Harry S. Gradle, Harry Culver, Walter Stevenson, Raymond W. McNealy.

Editorials

BACK TO NORMALCY

Now that the war is actually, even though not officially ended, the American people as a whole are anxious to see as quickly as possible, a return to normalcy. We are led to believe that the government was not expecting the sudden end of hostilities, and was not prepared to launch immediately the planned reconversion program.

With perhaps more than 12 million men and women in uniform, it is unquestionably a big task to get those who can be spared from further service back home. With approximately 62,000 medical officers with our armed forces, it is planned to release 13,000 by the end of the present year and perhaps an additional 17,000 within less than one year.

The physicians who had been in civilian practice left their work at the call of their country without regard to their practice or their future. They were inspired by the word that thousands of medical officers were needed to care for the large number of men under arms. That their services were used to good advantage is shown by the lowest mortality and morbidity rates ever known in modern warfare.

NEED ILLINOIS PHYSICIANS AT HOME

In Illinois, as in other states, so many physicians entered the services that many communities needed medical personnel. Only through the increase in patient loads, longer hours, and less time off from professional duties, were the remaining civilian physicians able to give adequate wartime medical care.

At a meeting of the Council of the Illinois State Medical Society held in Chicago on September 23rd, a resolution was passed which instructed the secretary of your society to notify all Illinois physicians in service that this Society was anxious to see all of them returned to private practice as soon as possible, and that every effort will be made that is within our power to accelerate the present program adopted for the release of physicians from service for the purpose of making adequate the medical service throughout Illinois.

The resolution as it was presented and adopted by the Council is as follows:

WHEREAS, approximately one-third of the physicians of the State of Illinois are now in service in the armed forces of the United States; and

WHEREAS, practically all of these officer physicians constitute most of the younger and more active members of the profession in the State of Illinois; and

WHEREAS, the loss of this medical manpower has placed a heavy burden on the older physicians of the State of Illinois and has also deprived many areas of the state of adequate medical services; and

WHEREAS, it has come to the attention of the Council of the Illinois State Medical Society that perhaps many of the physicians now in the armed forces could be released for return to private civilian practice in areas where medical service is sorely needed;

THEREFORE, BE IT RESOLVED That the Council of the Illinois State Medical Society request the Congressmen and Senators from the State of Illinois to interview the medical departments of the

various branches of the armed forces as to the feasibility of immediate acceleration of the present program adopted for the release of physicians from service for the purpose of making adequate the medical service in certain areas; and

BE IT FURTHER RESOLVED That a copy of this resolution be sent to each physician of the State of Illinois who is now in service of the armed forces.

Efforts will be made in every county to see that former patients return to their physician who responded to the call of his country for medical voluteers.

Many Illinois physicians had just finished internship or a residency when they were called into service, and had not yet opened an office for the practice of medicine. Information is being accumulated and will be maintained within the Society offices to give all possible aid to these returning veterans who desire information relative to a suitable location for practice.

Our medical schools are arranging refresher courses and complete information concerning these activities will be published regularly in the Illinois Medical Journal.

Physicians everywhere are anxious to see all medical officers desiring to be released from service to go into private practice, released as soon as possible. We all realize of course, that it will be necessary for the medical corps of the army, navy and public health service to maintain a sizable medical corps for some time to come.

Many letters have been received from medical officers stating that they not only want to come home to get back into civilian medical practice, but that they want something to come home to. Invariably they state that they do not want to participate in a federalized medical care program, and are willing to do their part in seeing that all of the people, regardless of financial status, receive adequate medical care.

Statistics and medical history alike show without question that where medical care is given through private initiative and unhampered by regimentation, the peeople receive better care and the total expense is lower than under any politically controlled plan.

MEDICAL PLANS IN ILLINOIS

At the present time a careful survey of all existing hospitals throughout Illinois, the current as well as the future needs of each community, is being made by the State Department of Public

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Health. In many communities either new hospitals are being planned, or additions to existing facilities are contemplated.

Most physicians are favorable to the development of prepayment plans for medical care for those in low income groups, but invariably all insist that these plans be conducted entirely on a voluntary basis.

It is also generally believed that only the residents of individual communities are capable of determining local needs, and that this cannot be done properly in any central office.

The Illinois State Medical Society has studied intensively during the past year the subject of prepayment plans for medical care, and it is believed that within a relatively short time, such a plan will be instituted in Illinois.

Throughout the war all physicians have cooperated in every way possible, both in the field and in civilian life, in the united effort to win this war. Physicians have been liberal purchasers of war bonds and they will continue to be during the final drive for our Victory Loan. They have given their services freely to all of the people regardless of their means. In most communities the interests of those absent physicians have been protected, and the officers will be welcomed home. Like all other patriotic citizens, physicians are anxious to see an end to unnecessary spending, a reduction from the all time high in wartime taxation, and as early a return of our men in uniform as is consistent with government demands for armies of occupation, and other essential needs.

ILLINOIS NATIONAL PHYSICIANS COMMITTEE

For a number of years the National Physicians Committee for the Extension of Medical Service has been functioning faithfully in its endeavor to enlighten the public concerning contributions which American Medicine has made and is making in behalf of the individual and the nation as a whole. The activities of this Committee have been endorsed by the House of Delegates of the American Medical Association and by most, if not all, of the component state societies. Official approval of activities was given by the Council of the Illinois State Medical Society in 1943.

At a meeting of the Council held in Chicago on July 29, 1945, a resolution was adopted whereby the Council approved the formation of an Illinois National Physicians Committee, the members of the Council to act as the control, or state committee. It was recommended that each Councilor District be organized to form committees with the Councilor in each District acting as chairman, and appointing representatives from various parts of his district to compose the personnel of this group of sub-committees. It was further recommended that each county medical society set up an N. P. C. committee, but to date we have not requested this action in Illinois.

The organization in Illinois is now complete and we are publishing it in full for your information.

The "control" or state committee is composed of members of the Council and the personnel is as follows:

E. P. Coleman, Canton — President of the State Society
R. S. Berghoff, Chicago — President-elect of the State Society and Secretary-Treasurer of the N.P.C. committee
Harold M. Camp, Monmouth — Secretary of the State Society

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A meeting was held in Chicago on Sunday, September 23rd, with representatives of the Councilor district committees present from each district in Illinois. There were approximately 60 present to receive information as to what is expected of the committee personnel collectively and individually. Many questions came up for discussion during the conference.

The National Physicians Committee for the Extension of Medical Service is to be congratulated for the work they have done and for their present activities. It is most timely that a suitable organization has been perfected in Illinois as has been done in many other states, to aid in these activities.

THE VICTORY LOAN; LET'S FINISH THE JOB

The Victory Loan Drive will be under way on October 29, and end December 8. The total amount expected from the drive is 11 billion dollars, the quota for individuals being $4 billion — $2 billion for E-bonds alone. Along with other members of the American public, physicians throughout the country have subscribed freely in the seven war loans and there is every

reason to believe they will again do their share in bringing he Victory Loan drive over the top. This will be the last of the war loans and it is quite obvious that the Government needs the money for specific purposes which are essential for the best interests of the country as a whole.

One of the biggest expenses for years to come will be the care of the wounded and the rehabilitation of veterans. Although the war is over so far as actual combat is concerned, there are hundreds of thousands of casualties many of whom will need prolonged care at Government expense. Huge sums of money are necessary to pay for war materials which were contracted for, produced and delivered months ago. Some contracts are being canceled and payment must be made to contractors for losses suffered. The sudden ending of the war was unpredictable, and many contracts for enormous amounts of materials had been made prior to its end, as every effort was being made to completely overcome the enemy with a minimum loss of life.

The expense of getting the millions of men home likewise is a big expense to the Government, and will require a considerable amount of money which the American people are willing to invest through bonds, for this important purpose. We owe a big debt to these fighting men who fought in combat, many receiving injuries, and will bear permanent disabilities throughout life. We cannot do too much for these brave men. It is well known that Government investments are the safest investments that can be made. Buy bonds and hold on to them until maturity, and you will be helping your Government the best way possible.

The Victory Loan officially begins October 29, and bonds can be bought in every Community throughout the United States. By buying them at home, credit will be given to your home community and with a spirited rivalry everywhere, it is most likely true that all states, and probably every county will be able to meet its quota, while many others will go well over the top on this last War Loan Drive.

BUY VICTORY LOAN BONDS:
"THEY FINISHED THEIR JOB —
LET'S FINISH OURS".

DOCTOR CITES TWO CASES OF MALARIA CONTRACTED FROM EX-SOLDIER

That the spread of malaria to civilians may have distinct possibilities is pointed out in the June 16 issue of *The Journal of the American Medical Association.*

S. B. Osgood, M.D., of Grants Pass, Ore., reports two proved cases of malaria, and possibly a third, which were contracted from a returned soldier having chronic malaria. This occurred in a rural area entirely free of this disease as far back as official medical records are available. The existence of anopheline mosquitoes, the carriers of the malaria blood parasite, had not even been suspected before the occurrence of these cases.

When anopheline mosquitoes feed on a person whose blood contains the malaria organism, these are drawn with the blood into the insect's stomach. There the parasites undergo certain changes, and after a week or so produce a number of spores. The spores find their way into the insect's salivary glands, and when the mosquito next bites another person, it injects the spores, together with its saliva, under the skin and into the blood—thus infecting the second person with malaria.

In this way, the returned soldier, who had contracted malaria in Australia, became the source of infection of the two Oregon patients. He lived on the bank of Grave Creek and the two patients lived nearby, within the flight range of anopheline mosquitoes. Anophelines were identified among mosquito specimens collected in their homes for investigation.

"It would appear," Dr. Osgood states, "that careful mosquito surveys must be made in this and other districts where climatic conditions permit the existence of anopheline vectors, and that active mosquito control measures must be instituted if an increased incidence of malaria and its establishment in new endemic areas is to be prevented."

State Department of Public Health

PENICILLIN REACTIONS IN THE TREATMENT OF GONORRHEA

Ever since Mahoney et al[1] announced the therapeutic value of penicillin in the treatment of early syphilis, warnings have appeared in the literature[2,3,4] as to the danger of masking or delaying the appearance of a syphilitic infection when penicillin is used in the treatment of gonorrhea. The amount of drug used in treating the latter disease, 100,000 to 200,000 units, is which, it is believed now, requires a minimum of totally inadequate for the "cure" of syphilis at least 1,200,000 units. The subcurative dose of 100,000 to 200,000 units is, however, sufficient to cause the disappearance of spirochetes in a chancre with subsequent healing of the lesion, but this is not to be interpreted as a sign of cure of the syphilitic infection. This warning is clearly demonstrated in a report of Sternberg and Turner[2] concerning a soldier who received 100,000 units of penicillin for a gonorrheal infection. A small ulcer on the frenum, present on the day of penicillin therapy, was not studied by darkfield examination until the following day at which time no spirochetes were demonstrable. Six weeks later the soldier developed a typical darkfield positive chancre at the same location.

Even in the absence of a genital lesion, the patient under penicillin therapy for gonorrhea may have acquired a concurrent syphilitic infection which at the time is in the incubation period. In this event, penicillin may delay the appearance of any manifestations of syphilis for as long as 60 days or may alter the usual course of the infection. As Van Slyke and Steinberg[5] point out, ". that early administration of penicillin (as in acute gonorrhea) may prevent the development of the primary lesion in concomitantly acquired syphilis, which is later manifested by a secondary eruption or by positive blood serologic reactions."

Chancres may also develop in areas, such as the urethra and cervix, where they are not readily detected and in the event that the blood Kahn is still negative, the syphilitic infection may be overlooked entirely. Such a case, reported by a clinic in 1944, is the following:

A.B., male, 28, married, had a discharge diagnosed as gonorrheal in origin which persisted after two courses of sulfathiazole and one of penicillin. When he reported after receiving a second course of 200,000 units of penicillin, he was found to have a mild eruption suspicious of secondary syphilis. Upon examination, his wife had a typical secondary eruption of longer duration and more marked than the husband. Symptoms disappeared in both cases promptly after beginning arsenical treatment. The medical history of both suggest that the husband probably infected the wife, his secondary symptoms being delayed by the penicillin treatment.

In treating any venereal disease, the physician, of course, should be alert to the possibility that the patient may have contracted more than one venereal disease at the time of exposure. Repeated observations and serologic tests for syphilis over a period of 3 months should be a part of the management of any case of gonorrhea. Now that we have a therapeutic agent effective in both gonorrhea and syphilis, such observation should be all the more rigid especially in view of the possibilities mentioned above.

One sign which should increase the physician's suspicion of syphilis is the development of fever during the course of penicillin therapy for gonorrhea. During the past six months the

attention of the Division of Venereal Disease Control has been directed toward 2 cases in which this phenomenon occurred. Both cases are of sufficient interest and reveal the probable significance of fever.

Case 1. N. W., white female, 19, married. On February 13, 1945 the diagnosis of gonorrhea was based upon positive cervical smears taken by a private physican. At that time the Kahn test was negative. Because the infection failed to respond to sulfathiazole, the patient was referred to the venereal disease clinic on February 28, when she was given penicillin on the basis of the information already known. In two to three hours after the first intramuscular injection of 25,000 units, the patient was emotionally upset and complained of headache, dizziness, nausea and abdominal pain; the temperature was 98.6 and pulse 92. Five hours after the second injection, the patient's temperature rose to a maximum of 104.6 and pulse 144. The Division of Venereal Disease Control was notified of this reaction on the same day and since no similar experience had been reported by other clinics using penicillin, the possibility of a Herxheimer reaction due to undetected syphilis was suggested. An examination on March 3 revealed inflammation of the cervix and vulva and although no chancre or secondary lesions were discovered, the clinician found evidences of a possible pre-existing cervical chancre. Subsequent Kahn tests after March 3 were persistently positive and the diagnosis of early asymptomatic syphilis was established.

Case 2. T.F.B., white female, 21, married. This patient was under the observation of the clinic for repeated gonorrheal infections from April 3, 1944 to April 2, 1945 during which time five Kahn tests were all negative. On April 2, 1945 cervical cultures revealed the presence of gonococci; there was no evidence of syphilis. She disappeared from the clinic until May 4 when she was again referred by the Police Department and at that time she was placed in the hospital for penicillin therapy for untreated gonorrhea. One hour after the second injection of 40,000 units, the patient complained of a chilly sensation followed by a feeling of warmth and aching pain about the shoulders. Examination revealed a temperature of 103 and pulse 116. No explanation of the fever could be found except for a moderately enlarged inguinal lymph node on the right. A third injection of penicillin was given 2 hours later and by the following morning her temperature was 98.6 and there were no complaints. On May 5 the examination showed no signs of primary or secondary syphilis; material aspirated from the lymph node was submitted for delayed darkfield examination but was negative; the blood Kahn, however, was positive (40 Kahn units). On May 7 the Kahn test was again positive (80 Kahn units), but the physical examination showed no abnormalities otherwise. The patient again disappeared from observation but the confirmed positive Kahn test and increase in titer strongly suggest the diagnosis of early asymptomatic syphilis.

The occurrence of fever in both of the above cases was in all probability due to penicillin, which, in the presence of undetected syphilis, gave rise to a Herxheimer reaction. Thomas and Meyer[6] in their study of 675 female cases of gonorrhea encountered 2 patients in whom a mild rise in temperature after penicillin treatment for gonorrhea led them to suspect the presence of syphilis. Although our own experience is limited to two cases, it is believed that fever developing under such circumstances should serve to warn the physician as to a possible concurrent syphilitic infection.

In general, therefore, the Division of Venereal Disease Control wishes to emphasize the following points in the management of gonorrhea: (1) The possibility of an intraurethral or cervical chancre should be borne in mind; (2) blood tests for syphilis should be included in the initial examination of all gonorrhea patients; (3) all suspicious lesions should be examined by the direct or delayed darkfield procedure before penicillin is administered; (4) patients should be watched for any signs suggesting syphilis during the administration of penicillin; (5) patients should be warned of the possibility of having acquired syphilis at the time they contracted gonorrhea; (6) following penicillin treatment for gonrrhea, patients should be examined for signs of syphilis and specimens of blood should be submitted for Kahn tests periodically over a period of at least 3 months.

SUMMARY

(1) Penicillin in the treatment of gonorrhea may mask or delay the appearance of newly acquired syphilis.

(2) Physicians should be alert to the possible presence of more than one venereal disease in a given patient.

(3) The development of fever in a patient under penicillin treatment for gonorrhea strongly suggests a syphilitic infection.

(4) Emphasis is given to certain points in the management of gonorrhea which will help the physician in the discovery of syphilis.

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DIVISION OF CANCER CONTROL

The Division of Cancer Control of the Illinois State Department of Public Health was created in 1939 by legislative action in response to a public demand. The law provided for an Advisory Board to the Division to be appointed by the Governor with the advice of the medical organizations. It also provided that the Chief of the Division be appointed by the Governor upon the recommendation of the Advisory Board. In 1945 the law was amended by the 64th General Assembly to provide for the appointment of the Chief of the Division by the State Director of Public Health under the State Civil Service regulations.

The present program of the Division includes the establishment and maintenance of tumor diagnostic facilities, professional education, statistical work, lay education, and general services to the professions and to the public in the cancer field.

The policies relating to these activities have been developed in close cooperation with the Cancer Committee of the State Medical Society. Guidance by the Advisory Board to the Division, consisting of physicians eminent in the cancer field, has insured the conservation of the interests of the practicing physician in every respect.

The membership of the Advisory Board at present includes: Roswell T. Pettit, M.D., Ottawa, *Chairman;* Edwin F. Hirsch, M.D., Chicago, *Secretary;* William Cooley, M.D., Peoria; James P. Simonds, M.D., Chicago; James S. Templeton, M.D., Pinckneyville; and John A. Wolfer, M.D., Chicago.

An extensive activity of the Division at present is the establishment and maintenance of Tumor Diagnostic Services in general hospitals throughout the State.

These Services are designed to provide convenient consultation facilities for the general practitioner in the care of his cancer cases, without charge to himself or to his patient. A diagnosis and recommendations for treatment are made by the Tumor Diagnostic Service staff, and the patient is directed back to the referring physician for further care.

As a supplementary feature of these clinical diagnostic facilities a free tissue diagnostic service for medically indigent patients is made available to all physicians throughout the State.

This work has had the formal approval of the House of Delegates of the State Medical Society since its inception in 1941.

With the present rapid and extensive development of scientific medicine in all its phases, physicians today must be familiar with the newer knowledge of diagnostic and therpeutic procedure in the cancer field in order to give the cancer patient the best possible care. The promotion of professional education in cancer accordingly ocupies an important place in the program of this Division.

Statistical research in the cancer field properly includes a study of the morbidity and mortality of the disease, epedemiological and sociological factors in its incidence, and the end results of treatment.

For purposes of such study a central file of case histories in abstract form of all patients admitted to the Tumor Diagnostic Services is maintained at Division headquarters. This file is particularly valuable in the follow-up of the cases registered.

In addition to the clinical data on Tumor Service cases, a duplicate slide of all biopsy specimens microscopically diagnosed at the cancer centers, together with a copy of the pathologist's report, is filed at Division headquarters. These slides and reports provide exact and valuable information to physicians who may be confronted with the problem of a cancer patient's further care after a lapse of years.

The value of lay education in cancer control is directly proportional to the availability of diagnostic and therapeutic facilities. In view of the imminent needs it has been the policy of this Division to continue our emphasis on the establishment of such facilities for the present.

The headquarters of the Division is located at 505 South Fifth Street, Champaign.

Correspondence

SOUTHERN ILLINOIS MEDICAL SOCIETY TO MEET

One of the first big medical meetings to be held in Illinois following the lifting of travel bans by the Office of Defense Transportation will be the annual meeting of the Southern Illinois Medical Society.

The program is an all day affair scheduled for November 8, 1945, at the Emmerson Hotel in Mt. Vernon. A complimentary luncheon will be served at 12:00 noon, and the dinner is set for 6:30 p.m.

The following program has been arranged by the officers, Dr. L. S. Barger, Golconda, president, and Dr. T. B. Williamson of Mt. Vernon, secretary and treasurer.

9:30 Welcome Address; Mayor Harry Bishop, Mt. Vernon.

9:45 "The Patient with Persistent and Unexplained Hoarseness"
Dr. Millard F. Arbuckle, St. Louis, Missouri.
Assistant Professor of Clinical Otolaryngology, Washington University School of Medicine.

10:15 "Neurosyphilis — Clinico-Pathological Considerations"
Dr. Ben W. Lichtenstein, Chicago, Illinois
Director of the Laboratories and State Neuropathologist.

10:45 15 minute intermission.

11:00 "Endocrine Therapy in Gynecology"
Dr. Frederick V. Emmert, St. Louis.
Associate in Gynecology, Barnard Skin and Cancer Hospital (Washington University).

11:30 "Your Every Day Pediatric Problems".
Dr. G. M. Cline, Bloomington.

12:00 Free Luncheon, Hotel Emmerson.

1:30 "Toxemias of Pregnancy"
Dr. F. H. Falls, Chicago.
Professor Obstetrics & Gynecology, University of Illinois.

2:00 "Goiter — Medical and Surgical Treatment"
Dr. Frank Deneen, Bloomington.

2:30 "Highlights of Modern Opthalmology of General Interest"
Dr. Bennett Y. Alvis, St. Louis.
Assistant Professor Clinical Opthalmology, St. Louis University.

3:00 15 minute intermission.

3:15 "More About Prostates"
Dr. Andy Hall, Jr., St. Louis.
Faculty, Washington University.

3:45 "Some Methods of Treatment of Certain Cancers of the Skin by the General Practitioner"
Dr. Charles F. Sherwin, St. Louis.
Associate Professor of Surgery, St. Louis University.

4:15 15 minute intermission.

4:30 Business Meeting.

6:30 Dinner, Hotel Emmerson.

7:30 "Post-War Medical Services — The Doctor's Role"
Dr. H. M. Camp, Monmouth, Illinois
Secretary, Illinois State Medical Society.

8:30 President's Address
Dr. L. S. Barger, Golconda, Illinois
President, Southern Illinois Medical Ass'n.

CONFERENCE ON TUBERCULOSIS

A Conference on Control of Tuberculosis in a Metropolitan Area, sponsored by the Institute of Medicine of Chicago, will be held on Tuesday and Wednesday, November 13 and 14, 1945, at the Palmer House, Chicago, and will cover phases that are of particular importance at this time to clinicians, specialists, lay workers, and teachers, who are cordially invited to attend.

For further information and programs address The Institute of Medicine of Chicago, 86 East Randolph Street, Chicago 1, Illinois.

THE WOMAN'S AUXILIARY TO THE ILLINOIS STATE MEDICAL SOCIETY

PRESIDENT'S MESSAGE

1945-1946

The whole world is on the threshold of a new era. With thanksgiving for peace and an ache in our hearts for those who are not returning, we again turn to those pursuits making up a normal and peaceful life. How our tasks will differ from those in the past, only the future will reveal. However, the depth of the accomplishment will equal the initiative and work put into it, as it always has.

The Auxiliary, which is made up of doctors' wives and works directly under the supervision of the Medical Society, has a much greater responsibility than ever before. This organization is in the position to give help to the medical profession and to the public which can not be obtained in any other way. An Auxiliary member is an informed woman who can act as a liaison in many other organizations in the fields of health education, public relations and medical legislation. The ability to act as this liaison can not be underestimated. Today women's groups play a great part in forming public opinion and directing legislation.

Upon special request of the Medical Society, the Auxiliary has put much stress on the Benevolence Fund. The need is becoming ever greater and the Auxiliary is proud to be able to participate in such a cause. It is to be hoped that this work will some day reach the point where all needy cases can be adequately covered. To reach this goal, the help of every member is necessary.

The State Auxiliary is fortunate in having a splendid Advisory Committee composed of Dr. Frank P. Hammond, Dr. R. K. Packard, Dr. Harold Camp, and Dr. S. E. Munson. The fact that the Auxiliary has had the cooperation and respect of this group has given much encouragement and incentive to the organization. If all counties would keep trying to develop a closer bond of understanding between their own group and the county medical society, much more rapid progress could be made. Both Auxiliary and Medical Society should have a definite knowledge of any special work to be accomplished by the Auxiliary. It is really very surprising that a great many doctors still believe the Auxiliary is only for tea parties.

The State Auxiliary wishes to welcome back the many members whose husbands have been in service. Many of our service wives are now returning and will find their Auxiliary has carried on under difficulties, but is eager and happy to have them home again.

Estella Gareiss

ILLINOIS DOCTORS PASS EXAMINATION FOR AMERICAN COLLEGE OF CHEST PHYSICIANS

The following physicians successfully passed the written examination for Fellowship in the American College of Chest Physicians held in June 1945, and will be awarded their Fellowship Certificates at the next Convocation of the College:

Dominic A. DePinto, M.D., Chicago, Illinois
F. C. Hammitt, M.D., Peoria, Illinois
Leo J. Latz, M.D., Chicago, Illinois
David F. Loewen, M.D., Decatur, Illinois.

The Convocations are held in conjunction with the annual meetings of the College which will again be resumed in 1946.

INTERNATIONAL COLLEGE OF SURGEONS CONVENTION IN WASHINGTON

The International College of Surgeons will hold its Tenth Annual Convention and Convocation on December 7th and 8th, 1945, at the Mayflower Hotel, Washington, D. C. At this time approximately 200 men will receive their Fellowship. A scientific program is arranged for both days. Convocation exercises will be held Friday evening, December 7th, in the Mayflower Auditorium.

HOLD OPEN HOUSE TO MARK 85TH ANNIVERSARY

On October 30th, J. E. Hanger, Inc., held an open house and public showing of their artificial legs, arms, and appliances to mark the 85th anniversary of the company.

In these 85 years more than a quarter million soldiers and civilians have been returned to normal lives through Hanger limbs, and now particular attention is being paid to the needs of returning veterans. The company has been cooperating with the Army and Navy, and with the Veterans Administration.

Medicine's Role in the War Effort

MEDICAL DEMOBILIZATION

NAVY

In the discharge of its obligation to the civilian public the Navy Department desires to accomplish as rapidly as possible the release of physicians, dentists, nurses and other officers and enlisted personnel of the Naval Reserve trained in medical fields. It is obvious that during the next few months they will be needed at almost full strength for the care, evacuation and disposition of the wounded and sick still coming from overseas and also in connection with general demobilization.

The transportation of wounded require full staffing at the point of departure, en route to the medical centers in the United States and within the naval hospitals and dispensaries of the continental United States. It should be remembered that the peak hospital census in military establishments in this country following V-E day was not reached until July 1.

The medical corps will perform a vital function over the next year or eighteen months in the separation process promised for over two and a half million men. Every man and woman returned to civilian life must be given a physical examination to include a chest x-ray, blood tests and any other testing individually indicated.

The necessary lag in medical demobilization behind general demobilization will be kept at an absolute minimum, and every effort will be made to respond at the earliest moment to the special needs of medical schools, teaching hospitals and individual and community hardship cases.

Effective September 15, therefore, the higher critical score for medical corps release is necessary, as announced in ALNAV 252. This critical score requires a total of 60 points* on the following basis:

½ point for each year of age, computed to nearest birthday.

½ point for each month of active duty from Sept. 1, 1939.

¼ point additional for each month of active duty outside the United States since Sept. 1, 1939 (effective Sept. 15, 1945).

10 points for a state of dependency existing as of Aug. 15, 1945.

On this basis it is determined that 1,128 medical officers will be eligible for release by September 15, 190 additional by November 1, 137 additional by December 1 and 223 additional by January 1, or a total of 1,678. Thereafter it is expected that critical scores for release will be lowered by degrees in order to carry out the present plan to separate a total of 8,000 medical officers by Sept. 1, 1946.

Many medical officers in the Reserve desire opportunities for "refresher" training before returning to civilian practice. Assignments to duty in United States naval hospitals afford one means of supplying such training, and the average period of time allotted for this specific purpose will probably be about three months.

Officers who elect to continue on active duty for a "refresher" period after becoming eligible for release under the point system may do so if they so request. The request may state that it is understood that this continuance on active duty after eligibility for release is for the purpose of obtaining an assignment in a specific type of service in a naval hospital for "refresher" training.

In a limited number of instances such assignments may be available and possible before the full 60 points of eligibility for release have been reached, but this "refresher" training by hospital assignments may retain an officer beyond the date when his point eligibility for release becomes effective. Periods of assignments of this type, constituting active duty in any United States naval hospital officially approved for graduate or residency type training, may be submitted for credits before the American colleges and the American boards with every likelihood of acceptance.

Plans are projected for the peacetime utilization of medical officers of the Reserve on inactive duty as consultants, lecturers or otherwise in naval hospitals near

*On October 8, this was lowered to 53 points. It was announced that 4000 navy reserve physicians will become eligible for release under the new score by Jan. 1, 1946.

their place of residence. Additional plans are under consideration in which the active assistance of reserve officers is desired and to be enlisted whereby junior medical officers in the regular Navy undergoing graduate training in United States naval hospitals may seek and obtain one year residency appointments in the foremost civilian institutions for the rounding out of their specialty training.

The graduate educational program of the medical corps of the regular Navy, already in full swing, and its peacetime administration offer inducement to medical officers of the Reserve to transfer to the regular Navy. This, it is hoped, may be sought by many.

The continued and active interest of our many reserve officers in the constant advancement of the medical corps of the United States Navy and in its aims is desired and solicited by the Bureau of Medicine and Surgery of the United States Navy.

ARMY

Following the termination of hostilities in Europe, the Surgeon General sought to build up maximum medical support in the Pacific for projected operations against Japan and simultaneously to provide an orderly system for the release of Medical Department officers after insuring that requirements would be met for the Army of Occupation in Europe and for hospitals in the United States with their large numbers of sick and wounded.

The early advent of V-J day necessitated radical changes in the Surgeon General's planning. The Pacific changed from a deficit theater in need of thousands of additional personnel for full-scale military operations to a surplus theater which had available for return large numbers of Medical Department personnel to the United States just as soon as the occupation of Japan had been completed. Improvement in the overall transportation situation likewise made it possible to accelerate the return of troops from the European and Mediterranean theaters, which presaged the more rapid return and separation of Medical Department personnel.

The cessation of hostilities in the Pacific also had important bearing on the large general and convalescent hospitals in the United States to which the more seriously sick and wounded are returned for definitive care. Except for small numbers of battle casualties now scattered through Pacific hospitals whose early return to the United States is a prime objective, no additional battle casualties will be evacuated and the patient flow from overseas will be limited to individuals with serious diseases or nonbattle injuries. This foreshadowed an early shrinkage in the general and convalescent hospitals at home.

The rapid demobilization of the Army during the coming months will necessitate the use of almost 2,000 Medical Corps officers at separation centers for final examinations. In addition, the large number of limited service personnel whose separation will be effected under the demobilization plan will further increase the requirement for Medical Corps officers for medical processing work.

Under the V-E plan, which was published in full in THE JOURNAL August 11, page 1104, it was necessary to establish adjusted service ratings for separation as high as 120 for scarce Medical Corps specialists and 100 for nonscarce Medical Corps officers. These high adjusted service ratings reflected the fact that the Army was in a position to release Medical Department personnel only very slowly as long as the war in the Pacific continued and large numbers of battle casualties in the United States hospitals had not yet completed their treatment.

The worldwide distribution of Medical Corps officers as of the beginning of September is estimated as follows: approximately 22,000 overseas, 11,000 in European theater and 9,000 in the Pacific and the Asiatic mainland; the remainder overseas are in other bases such as Newfoundland, the Middle East, on hospital ships, and in dispensaries of the Air Transport Command. There are about 16,000 in the United States, excluding 3,000 who are patients in hospitals and newly commissioned officers in training status. Another 4,000 were in transit to the Pacific as of V-J day; this group now becomes immediately available for separation or as replacements for high point individuals who can be separated immediately.

TABLE 1.—*Criteria for Separation*

Corps	Adjusted Service Ratings	Age	Length of Service
Medical Corps	80	48	Prior to Pearl Harbor*
Dental Corps	80	48	Prior to Pearl Harbor
Veterinary Corps ...	80	42	Prior to 1941
Sanitary Corps	70	42	Prior to Pearl Harbor
Medical Administrative Corps	70	42	Prior to Pearl Harbor
Army Nurse Corps† .	35	35	
Medical Department Dietitians†	40	40	
Physical therapists† .	40	40	

* Except grades A, B and C of ophthalmologists and otorhinolaryngologists, orthopedic surgeons and medical laboratory officers, all grades of neuropsychiatrists and plastic surgeons (prior to Jan. 1, 1941).

† In addition, married, dependents under 14.

Under the V-E plan, almost 1,500 Medical Corps officers have been separated. The Surgeon General testified on August 31 for the Military Affairs Committee of the House of Representatives that he planned to separate a total of 13,000 Medical Corps officers, 25,000 nurses and 3,500 dentists by the end of this year.

It is estimated that about 6,000 Medical Corps officers will be returned from Europe for separation and that an equivalent number can be released from personnel now in the United States. Surplus medical personnel will be returned from the Pacific as expeditiously as possible. A commission is now on its way to the Pacific to determine the exact number of surplus personnel. As already stated, 1,500 doctors have already been released under the V-E plan, and it now appears that the 13,000 estimate presented by the Surgeon General to Congress may be exceeded.

The original criteria for the release of Medical Corps officers were geared to adjusted service ratings and age. On the basis of both military and civilian reactions, a third factor, length of service, has been added.

Table 1 summarizes the criteria for separation, any one of which is basis for relief from active military service.

Despite the cessation of hostilities, a limited number of Medical Department personnel must still be sent from the United States to overseas theaters to permit the return of high score individuals for separation. The criteria presented in table 2 have been established to govern the selection of personnel for overseas service, except for volunteers. Individuals to go overseas must have a point score below that listed in the table or be below the age therin shown.

The separation criteria now in effect will have to be revised on or before the end of this year. Present plans contemplate the lowering of criteria during the first half of 1946, which will include a provision for length of service as a basis for separation of officers

TABLE 2.—*Criteria Governing Selection for Overseas Service*

Corps	Adjusted Service Ratings	Age
Medical Corps	45	40
Dental Corps	45	40
Sanitary Corps	45	35
Veterinary Corps	30	35
Medical Administrative Corps	30	35
Army Nurse Corps	12	30
Medical Department Dietitians, Physical Therapists	18	30

who came on active duty after Pearl Harbor. On the basis of a 2.5 million army, the Surgeon General will be able to release from V-E strength approximately 30,000 Medical Corps officers and 10,000 dentists and more than 40,000 nurses.

★ ★

GRADUATE AVIATION MEDICAL OFFICERS

Nine people from Illinois were among the 145 medical officers who completed the Aviation Medical Examiners' course today at the Army Air Forces School of Aviation Medicine, Randolph Field.

"Your training here has qualified you for the job ahead", stated Lt. Col. Fratis L. Duff, Ass't. Commandant of the Army Air Forces School of Aviation Medicine to the first peacetime graduating class of Flight Surgeons and Flight Nurses held since V-J day.

In speaking to the doctors and nurses especially trained in aviation medicine, Col. Duff explained, "Upon your shoulders will fall the accumulative tasks of caring for the sick and wounded servicemen being brought back to this country after many long years in Japanese prison camps".

The ones from Ill. completing the course were: Captain Edward T. Baumgart, MC, Danville, Ill., Captain Charles Barron, MC, Chicago, Ill., Captain Howard T. Barrett, MC, Pontiac, Ill., Captain Kenneth J. Moss, MC, Decatur, Ill., Captain Robert W. Thometz, MC, Oak Park, Ill., Major Robert B. Lewis, MC, Albany, Ill., First Lt. John N. Little, MC, Evanston, Ill., Captain Elmer E. Terrell, MC, Paris, Ill., Captain Henry M. Wilson Jr., MC, Peoria, Ill.

SEES NO CAUSE FOR ALARM THAT VETS WILL IMPORT DEADLY PARASITES

An army medical officer, writing in the September 1 issue of *The Journal of the American Medical Association*, says there is no need for alarm that military and civilian personnel returning to the United States from the tropics will import intestinal parasites capable of producing fatal or serious diseases.

Major Harry Most, Medical Corps, Army of the United States, carried out a study on 144 of the more than 1,000 passengers returned to the United States on the liner Gripsholm in December 1943, and found that 70 per cent of the passengers examined harbored one or more intestinal parasites.

"These parasites, for the most part, are not foreign to this country," he concluded, "and there is no basis for alarm about the spread of intestinal parasitic diseases in this country."

Major Most, who is on leave from his position as assistant professor of preventive medicine and medicine at the New York University College of Medicine, added, however, that "surveys for intestinal infections should be conducted on representative groups returning to this country to detect carriers so they may be treated. Food handlers should receive special attention."

The parasitologic studies were conducted in the Tropical Diseases Diagnostic Laboratory of the New York Health Department.

The study showed that 36 persons, or 25 per cent of the entire group examined, were infected with a type of parasite which causes chronic dysentery, intestinal ulcers and liver abscesses.

"It is interesting to note," Captain Most said, "that there were no infections found from hookworms."

Original Articles

GLOBAL DISEASE*

An Historical Perspective

DAVID J. DAVIS, M.D.
Dean Emeritus, College of Medicine,
University of Illinois,
CHICAGO

Some months ago in an issue of the U. S. Public Health Reports, the short statement appeared that two tse-tse flies had been found in a plane that had just landed in Brazil from Africa. Having thus been discovered, these flies did not get by. But they might have gotten by. For some years before (about 1930 or 1931) some aggressive mosquitoes, anopheles gambiae, from Africa, did land on this very shore in Brazil, possibly from a plane, or possibly from a destroyer, and before they and their offspring were finally exterminated, they had in one state alone infected 100,000 persons of whom 14,000 died. (Soper)

In discussing global diseases I might well use as a subject, this episode of the arrival in this Western Hemisphere of two stowaway flies from the Eastern Hemisphere, together will all that such a journey might imply. I can leave it to the imagination of the reader as to what might have happened if some tse-tse flies infected with trypanosoma gambiense had been as successful in their venture as had been the anopheles gambiar. For such arrivals and departures of insects, germs, viruses, and parasites passing from region to region and from continent to continent, living their lives and moving about in this world quite freely for the most part, have occurred in many devious ways even up to the present time. The improved and rapid transportation of human beings and animals has greatly facilitated the dissemination of these disease agents, a fact that has necessitated the creation of the specialty of disinfection and disinsection of planes, ships, trucks and trains on a scale hardly dreamed of a few years ago.

Many diseases from the beginning have tended to become global. The ancients were well aware of this, for throughout very early literature are brief references, usually a few words or a few sentences, from which we may learn something of the devastation of mass movements of disease. Such movements were called variously, in humans, an outbreak or an epidemic; or, if severe, a plague or a pestilence; and, when in animals, a murrain.

It was not, however, until the Plague of Athens in 430 B.C. that anything like an adequate report appeared of the destruction in mass of humans by disease, a phenomenon that had happened no doubt many times before and, we well know, has happened many times since. Thucydides, the Greek historian and scholar, was the reporter of the disaster. He lived in Athens at the time, and says that he himself took the disease and saw others suffering with it. Fortunately, he recovered, but many of his colleagues, including the great Pericles, died of it.

At that time in Greece the Spartans and the Athenians were engaged in a life and death struggle, the Pelopenesian War. This lasted, like our two world wars, some 25 years, ending with the defeat of the Athenians. From this disaster the Golden Age of Greece never fully recovered.

Read at the Annual Dinner of the Society of Internal Medicine of Chicago, May 21, 1945.

*In this paper, global disease refers primarily to infections and preventable diseases.

Thucydides decided to write a history of this war. This history may be divided into two parts, a long account of the military and political struggles and a shorter but far more vivid account of the Great Plague. This plague occurred during the second year of the war, quite as in the second year of World War I in 1918, the modern plague of influenza appeared. Thucydides says the plague started far to the south in Ethiopia, moved north to Egypt, west through Libya, east to Persia and north and west to Greece. To the people this was a global disease, for these countries included all the world they then knew.

Thucydides gives many facts about the disease including the symptoms. It was epidemic and contagious. It had appeared in former times. It was most fatal in crowded places like Athens. It was incurable. It was attended with despondency and moral depravity. The symptoms included high fever and thirst, redness of the eyes, bleeding of the throat and tongue, sneezing and hoarseness. The lungs later were attacked; which attacks were associated with violent cough. Small pustules and ulcers of the skin appeared and gangrene of the extremities was common. Death occurred on the 7th to the 9th day.

The devastation wrought in Athens was appalling. Thucydides' words remind one of our present day-to-day accounts in the papers of the horrors of the German and Japanese concentration camps. Bodies in heaps lay about the streets unburied for days, "the dead upon the dying and the dying upon the dead." Animals consumed the human bodies and in turn were afflicted. One-seventh of the population died. One-fourth of a military division died in forty days. The first period of the epidemic lasted three years. (430-428 B.C.) Later it reappeared. He noted that one attack conferred immunity; or if a second attack occurred it was never fatal[1].

Hippocrates lived at this very time. Possibly he witnessed this plague but this is not certain. Nowhere does he describe it as a definite epidemic, nor does he refer to it by name or place even in his books on The Epidemics. In this connection, though writing at great length on epidemics, Hippocrates, strange to say, nowhere recognizes contagion. This is the statement of Francis Adams, the well known classical scholar who translated all of Hippocrates's works as well as many other ancient medical classics. Hippocrates was thoroughly dominated by his first, second, third, fourth and fifth constitutions, conceptions which seemed in his mind to exclude contagion or to make such an assumption unnecessary.

What the Plague of Athens was, even our most authoritative scholars have never been able to determine. Typhus, small pox, bubonic plague, measles and influenza or a combination of two or more of these diseases have been given careful consideration. Some students have concluded that it was a disease not in existence at the present time.

The lucid and vivid description of this palgue by Thucydides places him high above all others as an early observer of epidemics. He easily became the Father of Epidemiology, as his contemporaries, Hippocrates became the Father of Medicine, and Herodotus, the Father of History.

This history of the Athenian Plague has had a far reaching influence on medical literature, even down to modern times. Diodorus followed Thucydides closely in describing the Plague of Syracuse in 395 B.C.; as did Livy in reporting a later epidemic in 212 B.C. Again Lucretius, 500 years later in his ambitious attempt to comprehend all nature in his poem, "De Rerum Natura", thought enough of Thucydides' history to include a long account of it, using many identical phrases. Later, the Plague of Marcus Aurelius, 164 A.D., of which Galen was a contemporary witness and writer, resembled the Plague of Athens. It lasted 50 years and ravaged the entire Greco-Roman world.

In the first century B.C., in the midst, as it were, of these devastating plagues, appeared one of the great writers of all time, the Roman poet, Virgil. He was a farmer. Louis Bromfield, in his recent book "Pleasant Valley," says a good farmer should be, among other things, a veterinarian, and such was Virgil. He loved animals and was an acute observer. Round about him he saw his animals destroyed by disease. So he wrote about this destruction devoting one of his Georgics to the animal plagues. In this instance there is no doubt about the diagnosis. His description is a classical one of anthrax. Here are samples of his lines. (translated)

"From tainted air arose a dreadful storm,
Inflamed by autumn's heat.

1. This was one of the first if not the very first reference to acquired immunity in disease.

And gave to death all cattle, tame or wild
Corrupting lakes, poisoning the grassy food."
And, also, (translated)
"Till men dig deep and bury them in earth
The skins are useless, nor the tainted flesh
Can water cleanse, nor raging fire subdue,
Nor is it possible to shear the fleece
So damaged with disease and filthiness,
Nor can the weaver touch the putrid web;
But should a man attempt the odious garb
With burning pimples and disgusting sweat
His limbs are seized and in no lengthened time,
The fire accursed consumes his poisoned frame."[2]

If one reads the important volume by George Fleming of England, published in 1871 on Animal Plagues, which includes much concerning human epidemics, one is struck by the enormous loss of life of both man and his domestic animals through the centuries. Year after year the figures run into the millions. Of these epidemics, anthrax, all things considered, was Enemy No. 1. Perhaps in more recent years we are forgetting anthrax and its history. But it is still a serious and widespread global disease and in many parts of the world it continues to be devastating to both animals and man. In regions of China, Russia, India, Africa and South America, the economic losses are great. As late as 1924 and 1925 in Russia alone (Gay) over 31,000 cases in man occurred. In its dissemination its pathways are often devious and long. Some of us remember the intriguing shaving brush epidemics here in this country about the time of the first World War.

Anthrax, with its broad pathogenic spectrum — man, cattle, sheep, goats, horses, swine, dogs, cats, laboratory animals and, at times, birds and fowl — is the disease par excellance that arose and became exquisitely adapted to live with and devastate the human race, its herds and flocks during the very long periods of time when man was evolving through the pastoral and agricultural stages of development. To this day, it continues to find favorable conditions in such agricultural regions. But in the great and rising industrial countries of the world, it is losing ground and in time probably will become relatively unimportant in these regions.

Anthrax, however, in recompense, as it were, for its atrocities, has furnished medicine much of its best material for the study of infectious diseases. A large spore forming organism, it was the first pathogenic germ to be seen by Rayer in 1850 in the blood of sick animals. Both Pasteur and Koch used it in their earliest classical experiments in bacteriology and immunology in many profitable ways. Let us hope the recent reports of its susceptibility to penicillin and other drugs may be substantiated for it has had a record of destruction of both animal and human life probably second to none. We should say too, that we owe much to the venerable investigators of this disease and we are doubly indebted to Virgil for having given to us 2000 years ago, in his incomparable verse, our first real introduction to anthrax, a description which in vividness and elegance of phrase has never been surpassed.

Through the centuries during and following the decline and fall of Rome, continued the deadly outbreaks of the global diseases with monotonous regularity. I will briefly mention only one, the Plague of Constantinople, also called the Plague of Justinian in the year 542 A.D. Gibbon, in his "Decline and Fall of the Roman Empire," gives at length the account of Procopius and other contemporaries of this plague. From their records there is no doubt that it was the bubonic plague. Gibbon's account is given in his masterly English style. "The mortality was extraordinary, even beyond conjecture. It continued with recessions for 52 years. At one period during three months, five, and at length, ten thousand persons died each day in Constantinople. Many cities in the east were vacant. The triple scourge, war, pestilence, and famine afflicted the subjects of Justinian and his reign is disgraced by a visible decrease in the human species, which has never been repaired in some of the fairest countries of the globe."[3]

During the Dark Ages there is evidence that these scourges continued, though records are scant. When the lights again began to shine about the year 1000 A.D., much of the world was still suffering from wide-spread epidemics and plagues. Leprosy had spread over a large

2. From George Fleming, Animal Plagues, London, Chapman and Hall, 1871.

3. The estimates of the dead in this plague run into many millions. The account is much like that of Boccaccio of the Black Death nearly a thousand years later in 1348.

part of Europe and the Black Death and many other pestilences continued to ravage the then known world for hundreds of years. Together they are known as the Great Epidemics of the Middle Ages, as described by Hecker and others.

This is an opportune time in our review of the more ancient global diseases to briefly mention the indebtedness of the medical pofession to general and classical literature. Among the references thus far given, the large number of contributions to medicine made by non-medical writers is significant. To these writers, historical medicine owes much. The records of some of these ancient diseases would be scant indeed without them. Most of the contributions, as indicated, concern the great pestilences, which being devastating and dramatic tragedies, furnished subjects suitable for the most talented literary writers of the time.

Here are listed several, some of which have already been mentioned:

1. The Plague of Athens, by Thucydides and later by Lucretius
2. Anthrax and the Animal Plagues, by Virgil
3. The Plague of Constantinople, also called the Justinian Plague of 542 A.D., by Gibbon
4. Black Death or Bubonic Plague of 1348 A.D. by Boccaccio in the Decameron
5. The Plague of London in 1665 by Defoe. (Defoe was seven years old at the time, but in his later years he described the Plague as if he had observed it as an adult.)[4]

Just at the close of the Middle Ages occurred the most important and far reaching event in history, namely, the discovery of the Western Hemisphere; two huge unknown continents sparsely inhabited by primitive peoples. It has taken a large part of the world 400 years to appreciate that this discovery was such a geat and far reaching event. Only just now are some nations of the world so convinced.

With the discovery of this western world began 400 years of the greatest migration on record, the mass movement of millions of people from east to west. A migration on such a scale had never occurred before and it can never occur again because there are no other worlds to discover. It has been said that the Europeans, especially the Spaniards, had a great field day on a magnificent scale during this long period, conquering, robbing, looting and dispensing their religion to the natives. That is, of course, only *one* way of putting it. But we should not forget, what secular historians have largely forgotten, that during this period there also occurred the greatest mass movements of all time of disease, parasites, germs, viruses, insects, along with their hosts. Wm. N. Fenton, (Smithsonian Re-) port, 1941, p. 503, Washington, D. C.,) of the Bureau of American Ethnology, in a special study, lists a formidable group of such imported diseases to this country as follows: venereal diseases, tuberculosis, measles, scarlet fever, diphtheria, chicken pox, small pox, typhus, typhoid, malaria and yellow fever. We should now add Malta fever. Much earlier, the Jesuit ethnologist, Lafitau, writes that "were it not for these introduced contagions, which carried a majority to their graves ere the prime of life, the otherwise rigorous constitutions of the Indians stood them to an extreme old age in which they had either to be knocked on the head, or suffered to go out like a light by a mere default of nature." (Quoted by Fenton.) Such an assault by new diseases, (together with alcohol) many of which were so deadly to the savages and against which their defenses were totally lacking, was a catastrophe that resulted in the near extermination of the natives in many of the tribes.

It was during these centuries and chiefly the 16th and 17th that so many serious diseases, which before that time were more or less regional, became global. As already stated, the movement was definitely from east to west and, in most instances, along the migration routes. For some diseases the evidence of the time of their arrival is fairly concrete. Small pox was reported in Florida early in the fifteen hundreds: also, further north in certain of the colonies, about the same time. And in 1682, literally, a boat load of small pox patients came over in the ship, Welcome, which was carrying the Quakers to Pennsylvania. On this one ship thirty persons died at sea of small pox. Naturally, the exact routes and time of arrival of the several diseases can, for the most part, never be known. But the fact that these diseases in Fenton's list were widely disseminated in Europe and that

4. And were we to go a step further, we could say, as was said by a great English physician, that one of the highest tributes and one of the finest character delineations of the Doctor was made, not by a medical man, but by that eminent Scotch writer and Divine, Ian MacLaren, in his immortal story "Beside the Bonny Brier Bush."

methods of control were almost totally lacking, seems ample evidence that the migration in mass of these diseases took place largely during the early colonial period. (see Heaton: Bull. of History of Medicine, 1945, Vol. 17, p.9)

But there are certain diseases apparently indigenous to the Western Hemisphere, which have played significant roles in history and which did not come from over seas. The records are not clear in all cases by any means.

There is the old and now threadbare story of pre-Columbian syphilis, that the sailors of Columbus carried back to Spain this infection which they had acquired from the natives in the West Indies. Sudhoff, the noted medical historian, doubts this origin of syphilis and offers evidence to the contrary, though it may be said that Dr. W. A. Pusey has analyzed the existing data in his monograph in the History of Syphilis and believes the theory well grounded. The important fact remains, however, that genuine syphilis did break out during the campaign of Charles VIII at Naples in 1495, spread rapidly over Europe, and then over the entire world in the form of an acute highly fatal epidemic, called the *morbus gallicus* or French disease. There seems little doubt that, wherever its ultimate origin may have been, it migrated from Europe to the Western Hemisphere largely with the Europeans in the 16th century.

Yellow fever, according to Tertre, was first recorded on the island of Guadaloupe in the West Indies in 1635. (McKinley) For a long time it existed primarily in South America, the West Indies, and in Africa. Its exact origin is shrouded in mystery. For at least 300 years, its main center was the West Indies and adjacent mainlands, where it reached its greatest intensity, and from which centers it spearheaded in various directions from time to time. It should be remembered, however, that the introduction of slaves from Africa may have carried the disease to the Western Hemisphere at an earlier period, and that Africa might have been the primary center with the West Indies and South America as secondary foci.

There are three other important diseases which seem definitely indigenous to the Western Hemisphere, and are still limited to this region so far as available data indicate.

First, Rocky Mountain spotted fever was apparently indigenous to our western states, though now we note it either has widely extended its distribution or possibly was present in a much larger area but unrecognized until very recently.

Second coccidioidomycosis seems indigenous to both South and North America. First recognized many years ago in Argentina, it was later found in the southwest especially in California. In many ways it simulates tuberculosis. The early cases observed consisted mainly of serious local lesions. Now it is recognized in the form of Valley fever or San Joaquin fever on an epidemic scale and widely distributed in the southwest. The recent significant work of Emmons (Arch. of Path., 1942, Vol. 34, p. 791) indicates that it may be primarily a fungus infection of soil rodents. The epidemiology of this disease is one of the most intriguing and instructive problems in this field at the present time. It is instructive, because apparently it furnishes an opportunity to observe the evolution of a recent or new disease. One must say "apparently" because it is difficult to say whether certain diseases are progressing or receding; or perhaps just stationary, that is, continuing their existence in a fairly well balanced environment. The difficulty is that we do not know the history of single strains of causative organisms.

The third Western Hemisphere disease is American trypanosomiasis, known also as Chagas disease. It appears in practically every country south of the Rio Grande, and triatomas, its vector, infected with trypanosoma cruzi have been found this side of the Mexican border in the United States. As yet no human cases have been recognized here. This disease apparently has been expanding on a wide front. Where or when it will stop is an unknown problem. The distribution of the trypanosomiases, of which their exist many in both man and animals in many parts of the world, is another intriguing phenomenon. This is especially true of the deadly African sleeping sickness carried by the tse-tse fly.

As to future possible mass movements of the great diseases of man and animals there is wide room for discussion and difference of opinion. In general, diseases in the past have moved from east to west along the routes of human migrations. as examples, influenza moved thus in 1918 as

also did Asiatic cholera during the last century; though in limited regions both exhibited variations. One striking exception to the east-west movements was the pandemic of bubonic plague when this disease was carried from Hongkong to California in 1900 and has been working eastward ever since in ground squirrels.

Having seen how this country in a general way was overrun by various diseases in recent times, let us now come closer home and briefly consider some past experiences of our central west. Situated in the very heart of this continent far from the infested shores of ocean traffic, we might expect some protection. But it does not seem to have worked out that way, judged by historical evidence.

Before the white man came to this country, as stated above, the Indians were fairly healthy, according to the testimony of early travelers and discoverers. They lived in the open air and had learned to live reasonably well with their own diseases. They were comparable to the range cattle on our Western Plains. Even up to 1750 and later, few global diseases had as yet afflicted them on a large scale. But this did not long continue, for, with the inceasing invasion of the country by the whites, roughly the late seventeen and early eighteen hundreds, both Indians and whites became heavily infected, chiefly with diseases of European origin. The writings of early physicians and travelers are replete with statements that the central west was seething with fevers and distempers. In certain localities, reports are extant by doctors that not one family was healthy and free from some serious affliction. Schoolcraft, the noted explorer and ethnologist, in passing through Illinois in the early eighteen twenties said, "I really believe it seldom happens that a greater proportion of an army falls victim to the sword during a campaign than there has of the inhabitants of Illinois to disease during the season that I have been here." (see: Ackerknecht, Malaria in the Upper Mississippi Valley, 1760-1900. Johns Hopkins Press, 1945, for literature and quotations.)

Malaria was the great curse. A large part of the entire country had been malarialized no doubt very early by the emigrants and, while the sources were probably numerous, two world distributing centers stand out conspicuously, an early one, the thousands of slaves from tropical Africa, and a later one, the larger number of people migrating to this country during the last century from southern Europe, especially Italy.

But malaria was not the only disease then rampant; I can only mention some others briefly. There was milk sickness, also called trembles, prevalent especially in the lowlands of many of the west central states. Great numbers of persons were made sick and many died. Not infrequently it was confused with malaria. It was caused by the poisoning of cattle from eating white snake root, and transferred to humans and other animals through milk, butter, and meat. For a long time the cause of this disease, (or poisoning) was a mystery. But in the last century, according to Rawlings, (Rise and Fall of Disease in Illinois, 1927, Illinois State Dept. of Health) Dr. A. J. Clay of Hoopeston, Illinois, determined the etiology by feeding experiments showing that *eupatorium urticaefolium* contained the toxic agent. The active principle is called trematol. It has never been isolated or analyzed and its nature still remains an intriguing research problem. Dr. Clay had suffered severely from the disease, having lost members of his family, relatives and friends, as well as his stock. Rawlings says Clay, a Doctor and Health Officer, deserves more credit than any other person in the control of this affliction. This was an early medical discovery of pioneer days of the first magnitude and merits more attention than it has received. This disease was common during the first half of the last century. As the country became settled and the land cultivated, the disease receded with the disappearance of the white snake root. Today, it is little known even by the profession.

Milk sickness has been popularized by the experience of Lincoln's family. When Tom Lincoln brought his family from Kentucky in 1816 into Spencer County, Indiana, he found the country infested with disease, particularly malaria and milk sickness. The mother, Nancy Hanks, died of the latter disease not long after their arrival, and later two other members of the Hanks' family succumbed. Large numbers of their cattle likewise died. It has been stated that the "milk sick", as Tom Lincoln called it, was one factor in later inducing him and his family to move to the Sangamon River country, thereby making Illinois the state of Abraham Lincoln.

For many details of this interesting medical episode in the life of the Lincoln family the reader is referred to Carl Sandberg's "Life of Lincoln".

Another disease that was global, par excellance, in its behavior and that several times ravaged America, was Asiatic cholera. Cholera has manifested its epidemicity chiefly in recent times, though probably endemic in India for hundreds of years. During the last century suddenly it flared up with violence and encircled the world four times, each time from east to west, and each time from India. In general, it followed the great travel and transportation routes. The first epidemic occurred from 1826-27, the second from 1848-57, the third from 1865-68 and the fourth from 1870-73.

The central west was directly in its path each time and suffered severely. The first epidemic was at the time of the Black Hawk War in 1832. It was so severe that this year became known as the cholera year. Nearly one fourth of General Winfield Scott's army of 1000 died of cholera, as many or more than died from combat service during the entire war. During the several epidemics, the loss of life was relatively enormous. No definite over-all statistics are available. This disease attacked people in all walks of life, rich and poor, prince and pauper, as one report put it.[5]

Yellow fever, in its occasional spearheads from about the Gulf of Mexico and the West Indies north along the Mississippi River, reached Illinois only twice. In 1878 in Cairo there were 80 cases with 62 deaths. In some ways the almost annual waves of paralyzing fear of yellow fever was more serious to the people in the central west than the disease itself. They continued until just after the Spanish-American War.

One could mention several other diseases, notably, typhoid and diphtheria, prevalent in the upper Mississippi Valley in its earlier years, all adding to the record of a region that, in former times, was anything but a health resort. But we must hasten to add that this territory was little, if any, worse than adjacent territories of the United States, most of which under comparable conditions, suffered about equally. We should say too, that during the past half century, all the states have met the problems of epidemic disease in such a way as to make the central west, at present, in such a sharp contrast with a century ago, one of the healthiest regions in the world.

In contrast with the positive problems concerning the progressive distribution of diseases are the numerous intriguing problems of a negative nature. On the several continents and in many regions, questions continually arise as to the dangers from the spread of epidemic and endemic diseases from adjacent areas; yet these dangers do not often materialize. To give only one example: why has not yellow fever advanced from Africa to southern Asia and to the East Indies? This problem has disturbed the peoples of the several nations concerned for a long time, since the conditions and factors existing in these countries seem favorable for the spread of this disease. There are also the associated questions as to why certain diseases rapidly invade a region and, then, perhaps promptly, or possibly after a long period of time, recede or disappear altogether. Asiatic cholera again furnishes a striking illustration of the behavior of such epidemics of which there are many. In this connection it is instructive to compare Asiatic cholera and typhoid fever, two intestinal diseases distributed largely by water and food and similar in other respects. While the cholera often tends to spread rapidly it also recedes rapidly and over large regions will completely disappear as happened in North America after the epidemics of the last century. Typhoid, on the other hand, seems more insidious and tends to be far more persistent in its endemic behavior.

The above statements serve to emphasize the biological nature of disease and to illustrate the fact that the distribution of agents of disease are quite comparable with the distribution of the fauna and flora of a region. While differing in almost infinite detail as regards such factors as nature of infecting agent, vector distribution, artificial and therapeutic measures, carrier state, climate, opportunist relations, nature and move-

5. The story of Asiatic cholera in the State of Illinois furnishes a most interesting chapter in medical history. Here was a disease that seemingly was so foreign to this country. Indigenous to lands on the other side of the globe, yet it was striking right and left with terrible effect in the very heart of a country which, in many ways, was still virgin territory. It was at this time, 1833, that Illinois' most eminent citizen, Gov. Ninian Edwards died of this disease. He had been the first territorial governor of Illinois from 1809 to 1818, one of Illinois' two first U. S. Senators, and governor of the State from 1824 to 1828. He was stricken at Belleville, Illinois. His son, Ninian Edwards, Jr., married one of the Todd sister. Later, Abraham Lincoln married the other in the Edwards' home in Springfield, Illinois.

ment of hosts, and in other ways too numerous to mention here, nevertheless, certain general laws and principles do apply and do determine, in each instance, the final result. Rarely, if ever, is only one factor alone operative.

Needless to say, both the general and specific studies on many, if not most of these factors, are in their incipiency. Illustrative of such investigations is that of Ackerknecht (loc. cit.) in which he points out that some dozen or more factors were concerned at times, in different degrees and in direct or indirect ways, in causing the recession or disappearance of malaria in the upper Mississippi Valley during the past century. The results of the evaluation of numerous factors having to do with the more or less regular recession of tuberculosis, now proceeding very generally, is likewise illustrative of the same general phenomenon. In this connection, too, one could cite striking examples from the list of contagious diseases.

Before closing, permit me to emphasize one point which can not be repeated too often, namely, that diseases come and diseases go. They may follow fairly definite patterns for a period but sooner or later they change their behavior in many ways; in intensity, in distribution, in attack rate, in aggressiveness, and, at times, in symptomatology. Epidemics, even of the same disease, become individual problems. They may mysteriously disappear from large areas only to return again at a later time. Such characteristics are strikingly biological. Their courses are essentially dynamic, not static.

There exists a group of diseases called, in some countries, the "Big Five", namely, bubonic plague, Asiatic cholera, small pox, typhus and yellow fever. They have been dramatic in their behavior, killing quickly and in large numbers, and moving, often rapidly, over large regions of the world. They are the diseases around which the quarantine systems of the nation for the past 400 years largely centered, and are the diseases covered by the International Sanitary Conventions. On the whole, they seem, at present, to be on their way out. We do not fear them as we did, though they require now, and will require careful watching in many parts of the world. This is especially true of typhus in its several forms.

Again, there is a second group of diseases less spectacular on the whole but more insidious, and often, in the long run, more deadly. This group includes tuberculosis, malaria, venereal diseases, influenza, (including colds) dysenteries, leprosy (in places) and some of the contagious diseases, notably, diphtheria. Gay, in his comprehensive work on Infectious Agents, states there are only four infectious diseases (really groups of diseases) that are universal in the world and names them as follows: the venereal diseases, (syphilis and gonorrhea,) tuberculosis, (human, bovine and avian) measles (and related contagions) and the influenzas. All these occur in this second group.†

Nearly all the above diseases we fear now more than we do the old "Big Five" of quarantine fame. But these diseases are being steadily conquered and most of them at present are receding rather than advancing.*

Again new diseases or diseases with which we are not well acquainted, especially epidemologically, are coming to the fore or just on the horizon, as it were. In this group we may include tularemia, epidemic jaundice, ornithosis, virus pneumonia, meningitis, enchapitis, poliomyelitis, murine typhus, Rocky Mountain spotted fever, filariasis, scrub typhus and some other tropicals now emerging under war conditions. Most of this group seem to be making headway, somewhere in the world. No doubt we know enough to curb most of them if we could apply our knowledge. All are being observed and in many regions much is being done to control them. But, as to the future of many of them, we have not a feeling of confident security. Only time can determine their ultimate course. We may be fairly sure that some of them or, perhaps some others, about which we know at present little or nothing, will, in the coming decades or centuries, give us as much concern as have many of the epidemic diseases of the present or the past.

The late Wendell Wilkie wrote a book "One World" which has been read by millions of people all over the globe. In this comprehensive

† No doubt some would amplify this list by adding especially the staphylococcus and strepto-pneumococcus groups and perhaps some others.

* In this connection it is somewhat startling to note that diphtheria has turned out to be the leading epidemic disease of the recent War in Europe. Stowman, J. A. M. A. 1945, Vol. 128, p. 185.

statement of globe problems a mere page or two was devoted to disease and to health problems. Yet today more than one half of the people of the world live under primitive health conditions, with practically none of the benefits of modern medicine and with death rates of 20 to 40 or more per thousand. Furthermore, as already stated, we know enough of many preventable diseases, as they behave at present, to control them either completely or to some degree. Now and following this global war, vast regions in various parts of the world, are being explored and made accessible for the first time to modern medicine.

In the present and forthcoming reorganization and reconversion program now being arranged all over the globe, there certainly should be a larger place for medicine and one worthy of its importance. The cost of a few battleships would go a long way in setting up such world programs. The Health Division of the old League of Nations was about the only part of the League's program that worked successfully, and which, by the way, is still operating. There are, in addition, a dozen or more effective regional or world groups or associations now in existence, all anxious for the creation of a comprehensive global health and medical program.

Lincoln said a country can not exist half free and half slave. Neither, in the long run, can the nations of the world live half clean and half infected.

And all the things said in this paper should remind us of an old saying that "no sickly people can be a great people."

The marked reduction in birth rates in occupied Europe may be due to multiple causes, possibly quite remote from wartime undernutrition, but the increase in infant mortality rates, in infantile rickets, and in tuberculosis among children is probably related to undernutrition and malnutrition. Foreign Letters, J.A.M.A., May 6 and 27, 1944.

Routine x-rays of patients, nurses, and other hospital employees will not only disclose unsuspected tuberculosis which is extremely important to the individual, but will also protect other patients and employees from the danger of infection. As more and more states are making tuberculosis a compensable disease, this factor will become increasingly important to hospital administration. Karl H. Pfeutze, M.D., Mineral Springs San., Cannon Falls, Minn.

ALCOHOLISM, A MEDICAL PROBLEM

R. S. Sabine, M.D.
MURPHYSBORO

In keeping with the precedent established by previous meetings of the Southern Illinois Medical Association, it becomes my duty and privilege, as President, to address you upon some subject pertinent to medical thought and ideals. It has been my opinion that the address of the president at our annual meeting should be along some line that will stimulate this group of men and women to go from this meeting with more determination to carry on the work of medical men, namely that of fighting the diseases of humanity and putting into practice the most effective therapy to cure or alleviate the sufferings of humanity.

With this thought in mind I have chosen a subject which will no doubt, be considered unusual. It may, indeed, be considered by some entirely out of order. It is, I admit, a subject that we, as doctors, have by-passed.

For forty years I have spent the greater part of my time in medical schools and hospitals, I have practiced medicine and surgery to the best of my ability, I have attended medical meetings and post-graduate schools of instruction, but, I am forced to admit that I have seldom heard a scientific presentation of the subject of which I wish to speak.

Yet during these forty years I have seen many lives snuffed out, many bodies torn and limbs broken, many patients sent to the insane asylums, all directly or indirectly because of the use of a drug, a drug so universally used in this day throughout the world that it has become a menace to civilization.

I am speaking of the drug alcohol.

It is my opinion that the ravages produced by alcohol upon the human body and intellect equal or excell in degree the ravages of either cancer, tuberculosis, syphillis, or any one of the other diseases which we, as doctors, spend our lives in fighting.

Historically, the use of alcohol can be traced back to earliest times. It is a curious fact that man has always found some drug which has the power to blot out, at least for a time, the realities of life, some drug that offers him an escape.

Presented as the Presidents address before Southern Illinois Medical Association in Carbondale, Ill., Nov. 9, 1944.

Possibly the best example is found in China, where opium is so universally used. Here we see millions of persons literally drugged. The use of alcohol has not been confined to any one nation but has been common to almost every race.

Samuelson[1] in his *History of Drink* states that in every nation there has been a period, just preceding the time of highest culture when alcoholism has been prevalent, but, during the period of highest culture there has been a drop in the use of alcohol. He states that during the decline from the state of culture the use of the drug has again become prevalent. The Greeks in celebrating the feast of the god Bacchus were given to orgies of intoxication but later, when culture was at its height, this intoxication was replaced by expressions in the fine arts. Again, in the early days of the Renaissance, sensualism and excessive use of alcohol were prevalent. As this condition receded there was an intellectual and moral awakening that affected all of Europe. In the early days of American history, the pioneering years, when men were undergoing the hardships of the frontier, alcoholism was common. Then followed a wave of temperance and a rise in culture, lasting for something over a century.

Today are we in a period of decline? We find a tavern in every block and almost on every crossroad, while most hotels combine bar and dining room. There are two taverns to every church, three to every public school. Under the stress of war and the strain of competition to which we are subjected in this day of materialism we are seeking escape from the realities of life by drugging ourselves with alcohol.

It would be improper at this time to go into too great detail in discussing the effects of alcohol upon the human economy, for you, as doctors, know well its effects. But let us consider briefly its effects as we would the symptoms of any disease.

Alcohol is a narcotic drug.

It is rapidly absorbed by an empty stomach, less rapidly by a stomach containing food. Only 2% is eliminated by the lungs and the kidneys; the remainder is taken up by the body fluids and undergoes oxidation.

It forms no tissues; it cannot be stored as energy; it offers no protection to body tissues.

It tends to neutralize the vital alkaline reserve by furnishing an excess of lactic acid.

No other drug is so remarkably diffusible, so quickly invades lymph, cerebral spinal fluids, bile, pancreatic juice, saliva, and even the amniotic fluid surrounding the unborn babe.

It is an irritant to the mucosa of the stomach and intestines, producing profuse mucous followed by nausea and vomiting.

Its chief effect however, is upon the nervous system. In this it has the peculiar property of removing the individual's repression, reserve, and inhibition, giving him a false sense of power and increased ability. Small amounts produce a sense of exhilaration and a general feeling of well being. It decreases the feeling of fatigue and gives to the individual an increased jollity and the idea of enhanced capacity for accomplishment and co-incident importance. The timid become brave, the silent become talkative and oratorical, and the songless ones are ready to soar to high C on "Sweet Adeline." Alcohol is an extremely effective agent for rosily blurring and softening the rigid and forbidding outlines of reality. It is a buffer between the individual and the disturbing impacts of unpleasant truths which he must face in his environment. This particular property doubtless explains the use of the drug by so many and, if these were the only things which alcohol could do to us, its use might be tolerated.

But let us examine more closely the effects of this drug. Although a drinker's speech may seem brilliant, it is often superficial in character. His movements are livlier, but poorly integrated and less accurately co-ordinated. A person who has taken a small amount of alcohol will make more errors, as, for example, in the addition of figures or the use of the typewriter, than he would have if he had not taken the drug, and at the same time he, because of a feeling of confidence, is unaware of his inferiority and actually believes he is better than usual.

On the organs of the special senses, especially the eye and brain centers, alcohol has a most unfortunate effect.

In small amounts alcohol causes a delay in response reflexes or trained responses to signals ranging from 5% to 15% of the usual response time and, at the same time, due to the release of

reserve and inhibition, the individual possesses a false sense of efficiency, and the rights of others dwindle in importance as his ego is inflated.

In order to interpret this effect more clearly, may I give you the results of scientific tests made, using two groups of fifty men each.[2] To the one group was given 1½ ounces of alcohol, the amount found in three ordinary highballs. The other group took no alcohol.

First: It was proven that those taking the alcohol were 9.7% slower in reaction to sights of danger than those who had not taken the drug. That is, if driving an auto at forty miles an hour, those of the alcoholic group would be five to eight feet nearer the danger before deciding that something should be done than those in the control group would be.

Second: The test showed that, after deciding that something should be done, those in the alcoholic group had a time of response in performing the necessary muscular action to avoid the danger, 17.4% slower than those in the control group had.

Third: A test was made to determine the power to concentrate the attention, as, for instance, in approaching an intersection where cars may be coming from different directions at the same time. In such a test, the highball men made 35% more errors than the control group.

Fourth: A test was made to determine the ability to co-ordinate the eye, hand, muscles, and concentrated attention, all of which are needed in safe driving. In this test the alcoholic men made 59% more errors than the control group.

These are facts scientifically established which should awaken us to the dangers of the use of alcohol upon the highway in this day of high speed.

Before the beginning of the present war, when the rate of speed was limited only by the horse power of the car, accidents, as you know, were appalling. Efforts to save many of the mangled bodies were fruitless and, before coroner's juries, you and I testified that this or that young person, man, woman, or child had died as the result of a fractured skull, cerebral hemorrhage, etc., due to an auto accident, when we knew deep down in our hearts that they had died because a driver's brain had been fogged by alcohol. More than 30,000 died in a year in automobile accidents and it is a matter of record that, in twenty-six states, 18% of these fatalities were directly due to the lessened efficiency of mind-muscle control caused by alcohol.

In New York City from 1928 to 1938 investigations, in which actual laboratory estimation of alcoholic content found in the brain of pedestrians killed by automobiles on the highway proved that over 30% were intoxicated at the time of fatal accident.[3]

54% of pedestrians killed by elevated or subway trains during this time were intoxicated, this fact also was proven in the laboratory examination of the amount of alcohol found in the brain.

Persons under the influence of alcohol loose all sense of care for themselves and traffic rules have no meaning for them.

If these fatalities have occurred in the traffic of today, what may we expect, following this war, when the airplane becomes a common means of travel?

What has been said so far applies to the use of only small amounts of alcohol. Larger amounts produce a more dramatic picture. The drinker undergoes mental confusion, loss of memory, change of personality. Some become noisy and boisterous, others sullen and quarrelsome. Association of ideas, initiative, reasoning, and judgment are all impaired, while emotional responses are explosive. Finally a drunken stupor ensues.

If drinking is continued over a period of time, a very large per cent of habitual so-called social drinkers undergo a depreciation of mentality and personality. They unconsciously pass into the class of abnormal drinkers, for the most tragic result of continued drinking is that the drinker developes a craving for alcohol comparable to the craving of the addict for morphine.

I can mention only a few of the effects of chronic alcoholism, but they are many. Certain types of neurotic or psychopathic persons need only a small amount of alcohol to bring on a trance in which they may do sensible things but are more apt to commit crimes or behave absurdly. Our hospitals for the criminal insane are full of such cases. Only recently at such an institution I talked with a doctor of excellent education and polished manners, but, who was an inmate of the institution. I was told that a

few drinks turned him into a moron. He was there convicted of the attempted rape of little girls. Another inmate had been convicted of the murder of five persons with an ax while under the influence of alcohol.

You have seen the person with delerium tremens as he fought or lay trembling in terror, seeing all sorts of terrible visions. I well recall a patient, a chronic alcoholic, who following an appendix operation, fought in such delerium for seven days when, in spite of all treatment given, he died of exhaustion.

It is well recognized that alcoholics are poorer risks for surgical operations than non-alcoholics. They also possess less resistance to infections and all serious diseases, such as pneumonia. The power of the white cell, that great defensive agent of the blood is reduced by the use of alcohol and mortality thereby increased. This fact has been proven in the laboratory as well as clinically.

The most powerful artificial or drug excitant to sexual excess is alcohol. More instances of syphillis and gonorrhea in young of both sexes, whose sober good intentions are to avoid extramarital sexual connections, have been due to alcoholic abuse than to any other cause. Alcohol in even small quantities lowers self restraint and self control in situations of sex temptation so that exposure to hazards of sexual diseases is undertaken thoughtlessly and without care for the consequences. A few days ago a fine looking young man came into my office and asked for an injection of bismuth, a drug, as you know, used in the treatment of syphillis. To test the truth of the statement which I have just made to you, I asked him if he were not under the influence of drink when he contracted the disease. He replied that he had been and that had he not been out on a little drinking party this thing would not have happened to him and that this was the most regretable experience of his whole life.

Alcohol is the best procurer known and is the constant and essential stock in trade of prostitution.

It is difficult to estimate the number of persons affected by alcohol. One authority estimates that there are at any given time in this country 200,000 addicts,[4] that is persons who are so enslaved by alcohol that they cannot help themselves, and 600,000 chronics, or persons who have developed some disease other than alcoholism as a result of the use of alcohol. These figures seem too small when we judge from our own observation of the members of our own communities. But they would be enormously larger if there were not so many of us trained never to use the drug. Dr. Robert S. Carroll, founder and medical director of Highland Hospital, Asheville, N. C., where a great many alcoholics are treated, makes this astounding statement, "It is startling to think that in our land, one out of three, whom we meet, is incapable of continuing any form of alcoholic usage without courting a very present danger of being wrecked or damaged by its potency."

That alcoholism is on the fearsome increase is shown by the statistics of insurance companies.[6] With hardly an exception these companies guard their finances by the rejection of, or increased rates on, alcoholic applicants for life insurance. One company reported for the five years ending in 1940 an increase of 183% of rejections for disability due to alcohol in the individuals under the age of thirty.

Since this paper is an effort to present only the medical phase of alcoholism, I cannot take time to touch upon the effects of alcohol upon a man's or woman's social, spiritual, economic, and home life, which after all constitute the most damaging effects of this drug.

Some may contend that this whole question is not a medical one but purely a personal matter. When, however, we note that the largest single cause for admission to the New York City hospitals in 1936 was drunkenness, just the ordinary "drunk" not including the thousands under treatment in these same hospitals for the diseases directly caused by alcohol, we are forced to admit that alcoholism is a medical problem. One hospital in Boston reports that it spends $370,000 a year in efforts to salvage drunkards. In our own state of Illinois 3,000 habitual drunkards appeal yearly to the courts of the state to be adjudged insane in order that they may receive treatment and the state must support these alcoholics for an average of 280 days at the cost of half a million dollars.[6] This overcrowding of hospitals by alcoholics is not only a great expense to the taxpayer but is a serious

problem for our institutions now understaffed because of the war effort.

Some who will agree that this is a medical problem will never the less say, "Men have always used alcohol and always will. If they want it, let them have it. Men and women should learn to handle their liquor. What can doctors do about it anyway?" If we admit, however, that alcohol does harm the body, intellect, and personality of men and women does it not then become our duty, as doctors, to try to do something about it?

I believe the members of the medical profession should be ever ready and willing to combat every disease and the use of any drug that has a tendency to lower the vitality of our patients. for purely medical reasons, if for no other. As doctors, we are in ceaseless search in the laboratories to find the causes of diseases, and we make endless experiments to find remedies for them. We spend a great deal of our time in educating our patients and the general public in ways to avoid disease and in the care of the sick. The state and federal governments are spending millions of dollars and building hundreds of hospitals to aid us in our work. How much of our time are we, as doctors, using to educate people concerning the effects of alcohol?

Here is a train of maladies that could be most easily prevented by persuading people to abstain from the use of this drug. Why can we not tell them that alcohol is a harmful drug which, like morphine, creates a habit and inform them, especially the young, of the effect of its use? Why cannot we see to it that these effects be effectively taught in our school under the head of physiology and hygiene? The young do not know that this drug is a source of danger. They see only the so-called social side of its use. They see their favorite hero or heroine in the movies drinking with such grace that they are charmed. Let us let them know the end results.

We can lift our voices as men of science, whose sole training and ambition is to protect human life, men, who have the respect and confidence of the people, to whom they look for guidance in matters of health, in creating a sentiment against the use of alcohol. Until public sentiment is aroused and people realize the danger, little can be done to control or eradicate the use of alcoholic beverages, for those who make and sell them for financial gain have so popularized their use by movie, radio, and the press that drinking has become the smart thing to do.

We have had remarkable success in educating the public to avoid other kinds of diseases. Our patients are now eager to be vaccinated against various diseases although there was much opposition to this at first. Taxpayers are willing to spend large sums of money to get a pure water supply and thus prevent typhoid. Who first made them aware of this need?

It is interesting to contrast the success we have had in educating the public against the use of the narcotics, morphine, heroin, and marijuana with the lack of success to the present time, in educating them to avoid the use of alcohol. No morphine is sold in public resorts in our country today as it is in China. Government agents constantly check even the very small amounts we doctors prescribe. The League of Nations had a commission at work to prevent the production and sale of morphine internationally. But how much money does the government — local, state, or federal — spend to fight the widespread use of alcohol?

As I wrote this paper another interesting contrast came to my mind. Recently in an English laboratory it was discovered that the broth from a certain kind of mold possessed the magic power to combat infection. The medical world was quick to grasp the importance of this discovery and now great plants are being built so that suffering men may regain health and thus be returned to normal productive life and to their family circles. What a contrast penicillin presents to alcohol! Great stills are built in both cases. Millions are invested in plants to manufacture alcoholic beverages which do not heal as does penicillin, but rather brings on disease, which do not restore the user to productive work but lower his ability to do it, which do not return him to his family circle but debase the finer sensibilities and bring suffering to the home life.

Is it not time for us as intelligent citizens and as doctors to speak out for sober thinking, for a clearer vision of our present condition, and strive for some concerted action to curb this malady which has always cursed humanity? As doctors, let us meet the challenge of this enemy

of men. Let us fight alcoholism in the same intelligent and fearless manner in which we have fought to eradicate tuberculosis, typhoid, and malaria. We, who have dedicated our lives to the sacred duty of guarding the health of our people should be in the front line in combatting, in every way, the spread of alcoholism which, like an epidemic of some dread plague now sweeps over the whole world.

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PUBLIC ASSISTANCE FOR THE BLIND IN ILLINOIS

Mr. Raymond H. Hilliard
Director, Illinois Public Aid Commission
SPRINGFIELD — CHICAGO

The Illinois Public Aid Commission has had the responsibility for the administration of the Blind Assistance Act since its passage in June of 1943. This act provides, as its name implies, assistance to needy blind persons and its provisions are such that Social Security funds are made available to meet 50% of the cost up to a maximum of $40.00 per month to a recipent.

Illinois had pioneered in assistance to the needy blind, being the first State in the Union to provide a pension for the needy blind. This law remained operative until the passage of Social Security legislation made it no longer necessary. This old law was passed in 1903 and was repealed in June, 1944.

Benefits under the old law were paid from state and county funds, while under the new law they are paid from state and federal funds. The old law provided a flat $30.00 pension to all beneficiaries whereas, under the new law, benefits are made available in accordance with need, up to a maximum of $40.00 a month. Property and income limitations under the old law were a fixed amount. Under the new law, they are related to the ordinary living arrangements and need of the individual. In addition, recent action by the Commission makes it possible to meet medical expenses over $40.00.

The Commission, at the beginning of the administration, recognized the need for skilled assistance in planning for the administration of this program. A Committee was, therefore, appointed to advise on the social and medical aspects of the program. The following persons were members of that Committee: Dr. Watson Gailey, Mr. Herbert F. Geisler, Dr. Harry S. Gradle, Miss Audrey M. Hayden, Mr. Samuel S. Holmes, Mr. Frank M. Lay, Dr. Charles H. Phifer, Dr. Walter Stevenson.

The medical members of this Committee have continued to serve as a technical advisory committee to the Commission. They have given generously of their time and knowledge and have contributed in no small measure to any success which the program may have had. Dr. J. R. Fitzgerald has served as Supervising Ophthalmologist for the statewide program from the very beginning and has performed a monumental task in determining the eligibility of persons in relation to their blindness.

In accordance with the provisions of the Blind Assistance Act, the Commission adopted a definition of blindness and selected the one set up by the House of Delegates of the American Medical Association. After a year's experience in the use of this definition, it was determined that the definition imposed certain inequalities so far as visual handicap is concerned. For instance, persons whose only visual handicap is a loss of visual acuity are not nearly so handicapped as persons who have lost the peripheral field of vision. In addition, there were some ocular conditions which constituted a visual handicap but could not be measured in terms of visual acuity or field loss.

Dr. Fitzgerald, with the assistance of our Sub-Committee on Ophthalmology, then formulated the new definition of blindness which became effective March 15, 1945. The new definition reads as follows:

"In terms of ophthalmic measurement, central visual acuity of 20/200 or less in the better eye, with correcting glasses, is generally considered economic blindness. A field loss in which the visual field efficiency is reduced to 30 per cent or less may be considered equally disabling, as may certain ocular conditions which do not necessarily involve visual acuity or

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peripheral field loss, but which constitute severe visual handicaps."

It is believed that this definition expresses the intent of the General Assembly in framing the Blind Assistance Act better than did the previous definition, because it more nearly equalizes the two types of visual disability through converting the ophthalmic measurements to percentages, giving additional weight to the handicap of loss of visual field, and making it possible to give consideration to persons who were disabled by such conditions as an essential blepharospasm, or an oculogyric crisis.

The Blind Assistance Act has as its purpose, the assistance of "needy blind persons" who have reached the age of 18, so the applicant for such assistance must furnish evidence of financial need, verification of age, and proof of blindness. Need is determined by an investigation of the applicant's resources, such as real and personal property, insurance, bank accounts, and the ability of his family to support. If this investigation establishes need, the applicant has an ocular examination by a physician skilled in the diseases of the eye to determine whether or not he is blind.

Upon the recommendation of our Sub-Committee, the panel examiners in the Blind Assistance program in Cook County were limited to those ophthalmologists who had been certified by the American Board of Ophthalmology. However, the large number of examinations and the scarcity of certificated men in downstate Illinois, made it necessary to request the services of other men who had an eye, ear, nose, and throat practice. The names of these men were submitted to the Committee for their approval before they were invited to participate. At this point, I wish to commend all of those physicians who undertook to help us in doing these examinations. The ophthalmologists of this State examined about 5000 applicants for Blind Assistance in a period of nine months, in addition to carrying on their normal practice. It was a tremendous job — very well done.

Wherever possible, the applicant is given the names of panel examiners in his community and is permitted to choose the one he wishes to do the examination. The examiner reports his findings on a form which the Commission supplies and mails it to the Supervising Ophthalmologist (Dr. J. R. Fitzgerald) who reviews and evaluates the findings in terms of the definition I read a few moments ago. If the recorded evidence of the ocular findings substantiate or prove the applicant's vision is consistent with the opthalmic measurements of the definition of blindness, Dr. Fitzgerald certifies that he is blind. The Blind Assistance Act requires that all recipients have ocular re-examinations at the discretion of the Supervising Ophthalmologist, or at least every three years unless excused from further examinations by the Commission.

At the time this program began, there were 6790 persons receiving a blind pension from the various counties. Most of those persons made application for Blind Assistance but a large percentage were rejected because they had sufficient resources, or were not in need of assistance. Some 10% were rejected as "not blind" after an ocular examination. In April of this year there were 5188 persons receiving an average Blind Assistance grant of $33.30; 1910 of these persons reside in Cook County.

We often think of assistance in terms of money, but in actual practice we find our Blind Assistance recipients in need of many services, one of which is medical care. The ocular examination reports and the examiners' comments have given us indications of some of the medical needs of our recipients. The recommendations for treatment of the eye condition and, sometimes, of a physical condition, are forwarded to the county departments when notice of eligibility or ineligibility is sent. The county department visitor then discusses the problem with the recipient, and if he is not already under care of a physician, attempts to plan for such care. Through this medical assistance program a definite contribution is being made toward the total effort to control infectious conditions such as trachoma, and syphilis, to sight conservation programs, and to correction and amelioration of general health problems. One of the direct results of medical assistance has been the improvement of vision of 86 persons by helping them to make arrangements for cataract surgery. Most of this surgery has been done through public institutions such as the Cook County Hospital and the Illinois Eye and Ear Infirmary, except in a few instances where relatives or other interested persons have contributed the cost of

care by private physicians or clinics.

In the Blind Assistance program, the medical needs of the recipients for care other than restorative surgery are met through an increase in the assistance grant, and through payment from State funds for certain expenses. The costs of physicians' service, drugs, appliances, nursing service, hospital care, and nursing home care are met in this way. There are some needs which arise because the person is blind, so there are special allowances for such items as guide service, telephone service, and educational recreational material.

Other services which Blind Assistance recipients may receive, are related to social and economic rehabilitation. Examples of such services are the following: finding a nursing home for the Blind Assistance recipient who needs some nursing and personal care in addition to board and room, making arrangements for another recipient to live in town for a few months while taking lessons in Braille. An illustration of the complex need of our recipients is presented in the story of a downstate man who was blind at the age of 21 because of trachoma.

Our visitor called to discuss the ophthalmologist's recommendations which had accompanied the statement that he was visually eligible for Blind Assistance. There was no hope of improving his vision — all that treatment offered was a degree of comfort and protection to others. Leslie had never received treatment for his eyes because his mother thought there was no profit to be derived and she had little faith in the services of the facilities available in the community. The father also has trachoma but the mother and six siblings have not caught the disease. The visitor instructed the mother in those hygienic measures which would protect the other members of the family and asked the County Nurse to call at this home in a further effort to obtain the family's co-operation in a plan for treatment of the trachoma. Leslie quit school in the second grade because he could not see. He is incapable of caring for himself so depends upon his mother. For the most part he sits in his chair most of the day with his head hung and his cap drawn low over his eyes. Finally, the visitor learned he could do a few things with his hands. He likes to make small wooden windmills which show the direction from which the wind comes. He has several of these about the place and proudly displayed them to the visitor. He also had made a few keys from old scraps of metal and said he would like to do such work as this. The visitor secured some old material and gathered up quite a few keys for him to copy, then took them to him. Leslie also stated at the time of the last home visit that he would like to try to raise some pigs but he was afraid that if he did this, the amount of his pension might be decreased. He was given to understand that his income would be applied to his other needs first, so, if as he said, his brother would give him a start of pigs, it would be a very fine thing for him to take care of them and help provide meat.

When Leslie's interest was aroused, a referral for home teaching was suggested. This Leslie desired, and in order to learn to do things with his hands, he finally undertook treatment to render his trachoma inactive, because the home teacher could not help him until the trachoma became non-infectious. After this man learns to do things for himself it will be possible to attempt some form of vocational training.

There are many situations in which the recipient needs the services of agencies skilled in special areas. When this is the case, referrals are made to the agency that offers the service needed. To facilitate such referrals, the Commission has worked out co-operative agreements with the Division of Visitation of the Adult Blind, Division of Vocational Rehabilitation, Illinois Eye and Ear Infirmary, Cook County Hospital, the sheltered work shop of the Department of Public Welfare, Trachoma Clinics, and many private social and welfare agencies.

Because the county department staffs had little experience in the area of service to blind people, it was necessary to give them an understanding of the problems caused by blindness. The American Foundation for the Blind has helped with this problem by sending staff members who conducted institutes throughout the State.

Illinois has done much to improve and extend programs of services for the blind, but there are areas in which we must make further effort to meet the needs of this group. I will mention a few of these problems: there are many newly blinded persons who need help in becoming ad-

justed to the handicap, but the services available are so limited in staff and funds this help is usually not available when it would be most effective.

There are many employable blind persons who are without special skills or who find no job opportunities in the small communities where they live. Are we going to "colonize" them in larger cities where all training facilities and job opportunities now exist, or are we going to help them become self-supporting in their own community? The same problem exists in respect to those who could be partially self-supporting through a home industry program.

There is an unknown number of infants and children under school age whose parents are in need of services to help them with the problems of rearing a blind child. Such service is not available anywhere in this State.

We have Braille classes in the Chicago schools but a blind child residing in any other community in the State must sever all his home ties and go to Jacksonville, or forego formal schooling, although there are State funds which could be used to reimburse the local school board for the additional expenses of his education in the public school.

There is a very fine and effective private agency for the prevention of blindness, the Illinois Society for the Prevention of Blindness, of which Miss Audrey Hayden is Executive Secretary, but there is no State agency for follow-up of those who will eventually become blind if medical care of the eye condition is not insured. This should not be the responsibility of the private agency, which does a research and educational job, pointing out needs for which government should make plans.

IMPORTANT

Send changes of address to 30 N. Michigan Ave., Chicago 2, Illinois, enclosing label from a copy showing your old address. Changes received after the 1st of the month will not go into effect until the following month.

SPIROCHAETES IN FECES

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While carrying on a certain research problem in North Africa we had occasion to make numerous darkfield examinations of feces. The frequency with which spirochaetes were found and the dearth of information on this subject in the average textbook of bacteriology led us to record the observations made.

Studies were made on 199 patients in a general hospital. Of these, 140 were cases of epidemic hepatitis and 59 were miscellaneous nonfebrile medical cases. Approximately 300 fecal darkfield examinations were made. On the basis of one stool examination spirochaetes were found in the stools of 24 per cent of the patients with epidemic hepatitis and of 23 per cent of the miscellaneous cases. When examinations were repeated on the initial negatives among the cases of hepatitis, the number of positives found increased from 24 to 30 per cent.

The spirochaetes appeared to be of the Borrelia type. They were quite flexible, had shallow wavy spirals as a rule, and tapering pointed ends. The length varied approximately from 8 to 15 micra, and the width was about 0.25 micron. Most of the organisms contained two to three spirals, but longer ones were not uncommon, the maximum number of spirals being five or six. In most instances the spirochaetes were sluggishly motile or had lost their motility. In other cases, however, they were actively motile. Fusiform bacilli were commonly present and occasionally occurred in large numbers. The organisms stained excellently with the Fontana — Tribondeau spirochaetal stain. Repeated examinations in certain individuals in whom they were demonstrated showed them to be persistent and to be present as long as four weeks after first identification.

Since we were at the time experimenting with small laboratory animals, as a point of interest, we decided to make similar observations on their intestinal excreta. Of 16 white mice, two showed similar spirochaetes in the feces. The stools of three rabbits failed to reveal such organisms. In 12 autopsied guinea pigs darkfield examinations were made of the contents of the small and

*The author is on leave of absence from the School of Public Health, University of Michigan, Ann Arbor, Michigan.

large intestines. Spirochaetes were not present in the small intestine, but in 11 instances they were found in the large intestine. In the guinea pigs the longer type of spirochaete predominated. In both the mice and guinea pigs active motility was more consistently present than in humans.

Since the spirochaetes found in humans had no etiological relationship to the malady present, it can be assumed that their presence represented more or less a normal picture. It would not appear that diet was an influencing factor since the cases of hepatitis were on a low fat diet and the others on a general diet.

If the findings in guinea pigs may be considered to be of significance, apparently the habitat of such spirochaetes is in the large intestine and not in the small intestine.

In a study of 543 penile lesions we found significant numbers of spirochaetes of the Borrelia type and fusiform bacilli to be present in 8.5 per cent of the cases. If we had included those instances in which these organisms were present but infrequent, the per cent of occurrence would have been higher. The source of these organisms at the time was debatable. Correlating our findings in the feces with the findings on the penile lesions, it is suggested that contamination of the penile lesions may have occurred as a result of deposits of the fecal flora on the genitalia. This would be particularly favored in military life due to the difficulty in maintaining meticulous personal hygiene.

SUMMARY

1. In 199 persons studied, approximately one out of every four showed the presence of spirochaetes of the Borrelia type in the feces. This could probably be interpreted as representing the normal picture.

2. A low fat diet did not seem to influence the frequency of this occurrence.

3. Observations on guinea pigs suggest that spirochaetes are normally present in the large intestine but not in the small intestine.

4. Spirochaetes form a part of the normal flora of the feces of mice and guinea pigs as well as of humans.

5. It is suggested that since spirochaetes of the Borrelia type are commonly found in the feces, fecal contamination of penile lesions may account for the presence of similar organisms in such lesions.

Acknowledgement is made of the valuable technical assistance of F. C. Heneman, Jr., Technician 4th Grade in the above studies.

EXAMINATION OF STRABISMUS PATIENTS WITH INDICATIONS FOR TREATMENT

George Guibor, M.D.
CHICAGO

The problems occurring in the treatment of strabismus in children differ in many respects from those arising in the treatment of similar neuromotor disturbances in adults. We must realize that the child has a greater ability for recovering from motor disturbances than the adult. This fact has been demonstrated by Margaret Kennard, who removed portions of the cerebral cortex from infants and mature monkeys. The motor disturbances resulting from these ablation experiments were similar in both groups. The degree of recovery, however, among the younger monkeys was considerable, while that of the mature group was small. Thus the hemiplegia resulting from ablation of the unilateral cerebral cortex decreased or disappeared in the infants probably as a result of the growth or development of new association pathways in the motor system. The hemiplegia persisted in the adult because of the inflexibility of the nervous system.

A second reason may be given which helps us to understand why the problems of treating strabismus in children are different from those involved in treating squint in adults. This is the fact that the neuromotor coordinating mechanism for the eyes in children is relatively undeveloped while that in adults or youths is developed and more fixed. Therefore, many squints in children are variable while those in older groups are constant. This allows the possible development of new association pathways, and new conditioned reflexes in the child. We must all agree that it is difficult to teach an old dog new tricks. This results because his motor pathways are more fixed than in a pup. In fact it is

From the Department of Ophthalmology, Children's Memorial Hospital, Chicago.

Presented before the Section on Ophthalmology, Illinois State Medical Society, May 16, 1944.

at times impossible to teach an old dog any tricks.

A third fact to be remembered is that the degenerative components of squint are rare in children. Contractures of the internal recti and relaxation of the externi are not seen as often in children as in adults. This fact compels the oculist to employ surgery more often in treating adults with squint than in treating children.

Fourth, one must remember that the causes of squint in children are often different from the causes of motor defects in adults. The causes of motor defects in children may be: (1) congenital or familial deficiencies, (2) refractive errors, (3) mechanical distortions of the orbit, (4) childhood infections, especially pertussis, (5) encephalitis, (6) anoxemia and trauma which occurred during birth, and (7) fusion disturbances. The common causes of squint in adults are: (1) trauma, (2) syphilis, and (3) vascular accidents.

Finally, a child is more amenable to nonsurgical technique. He accepts an overcorrection of his ametropia, occlusion, and atropinization of his eyes without complaints; whereas adults often complain considerably when given such treatments.

From these observations we must conclude that the diagnosis and the treatment for squint in children should be different from the diagnosis and the treatment for the corresponding defect in adults. The average child has excellent ability to recover from his ocular motor defects because he has an undeveloped neuromotor system, fewer degenerations in his muscles, and will cooperate better than the adult. Finally, the immediate causes of squint in adults are different from the causes of childhood squint.

In this treatment of children with strabismus one must decide upon the cause of the deviation if possible, upon the type of treatment, and length of time which will produce the best cosmetic and functional results. In order to make these decisions, let us ask ourselves what we are attempting to do when treating squint. The oculist often believes that we are treating the fusion center. The neurologist tells us that we are treating motor areas located in the frontal and occipital cortex, visual centers and pathways leading from them to the occipital cortex, proprioceptive pathways, and the association centers joining these three groups or components. If these components — motor, visual and proprioceptive are to be treated, what methods of treatment will give us the desired results? Let us ennumerate the methods which involve the use of: (1) refraction (2) cycloplegics (3) prisms (4) occlusion (5) fusion exercises (6) general medical treatment (7) surgery and (8) combinations of these.

In order to select the proper treatment from such a therapeutic aramentarium one must thoroughly understand the type of squint involved, that is, whether it it esotropia or exotropia, supranuclear or infranuclear. It also must be understood that the time consumed by the treatment of choice will depend to a very great extent upon the age of the child.

Squint must be recognized as the result of disturbed neuromotor function so that binocular vision and binocular fixation are absent. In other words, the problems of treating squint are problems of neurology. Allow me to present an example to demonstrate my point. Does the neurologist say to the mother of a child with a spastic hemiplegia, "Unless your son recovers in six months he should have some operative treatment?" No, he does not. He recognizes the fact that the defective motor centers in the cortex of the cerebrum must become reorganized so the compensation in other centers may occur. Thus only when mechanical defects occur does he consider surgery. Such defects are contractures of spastic muscles or a relaxation of their opponents.

The oculist should do likewise. He should realize that time is required to produce improvement in the defective motor centers which should control the movements of the eyes and that a few months to one year are not always adequate to wait before doing surgery. These motor centers in order to become reorganized must be given nonsurgical help in the form of glasses, prisms, cycloplegics and orthoptic exercises. Only when recovery is incomplete after years of this treatment should surgery be undertaken.

On the other hand, if a mechanical defect such as weakness of an external rectus occurs during this time, then surgery may be utilized to overcome this defect. Proper nonsurgical treatment, however, will often prevent such defects from presenting themselves.

Thus the treatment of a child with squint requires the use of some of the specialized methods just presented. Let us discuss these methods and the cases in which they are indicated.

Refraction. — Refraction is the determination of the errors of refraction and the prescribing of the necessary lenses to correct the ametropia. Of all the methods at our disposal this method of treating motor anomalies is the most valuable, especially if one includes the prescribing of prisms in his refractive routine.

The reason for this assertion is that a lens properly prescribed affects: (1) the accommodation (2) the convergence (3) the divergence (4) the vertical centers (5) the visual acuity (6) the fusion center (7) synaptic and association pathways (8) local stability of the eyes, and (9) general stability of the patient.

Prisms. — If, however, the motor defect is in the supranuclear pathways or centers then prisms are indicated to allow an approximation of the visual axes. This approximation will stimulate pathways and centers for binocular vision and will encourage other less defective motor centers than those allowing the squint to reorganize and take over the function of the defective centers. Thus the squint decreases not because the muscles have been aided but because the motor, visual and proprioceptive centers have been stimulated by the refraction and prisms. In order to bring about this reorganization, however, it should be clearly understood that the squint should be only partially corrected by prisms.

A number of general rules should be given to one who wishes to use prisms in esotropia.

1. The squint must be differentiated from the phoria.
2. The squint must be measured quantitatively in prism diopters at both far and near fixation with glasses and under a cycloplegia.
3. One third of the squint must be corrected by prisms, especially if the angle of strabismus is a variable one.
4. Objects are deflected toward the apex (apparently).
5. The apex is prescribed in the direction of the deviation as follows: Apex in for esotropia, apex out for exotropia, apex up for hypertropia, and apex down for hypotropia.
6. A greater amount of prism is placed in front of the fixing eye in patients with esotropia than before the suppressed eye.
7. In paralytic squint a greater amount of prism is placed before the nonparalytic eye than before the paretic eye. This is gradually reduced and the prism before the paralytic eye is increased until the visual axes are parallel.

Atropine. — To the author atropine is the second most valuable aid in treating squint. It not only blurs vision but is an antispasmodic. As such it is used in the eyes of infants too young to be refracted. Atropine is used to treat amblyopia by instilling the drops in the fixing eye, later in the amblyopic eye.

Improvement with atropine may not be apparent for several months except in cases of accommodative strabismus. Here, of course, a rapid or immediate improvement can be seen when the eyes are atropinized.

A cycloplegic is exceedingly valuable in cases of patients who have been operated upon. In these cases one wishes to keep the accommodative convergence relaxed for at least one month to allow the function of divergence ability to improve and to decrease the possibilities for sutures and for the fibrous connections between the bulb and the muscles from stretching.

Occlusion. — The covering of one eye or the alternate covering of each eye is valuable in improving visual acuity and in treating anomalous correspondence. In severe loss of visual acuity (20/65 or less) occlusion of the fixing eye is preferable to atropine. It is especially valuable in conjunction with the atropinization of the fixing eye.

Fusion Exercises. — The binocular simultaneous stimulation of both eyes by photographs or objects and their correlation and projection may be called fusion exercises. This training can be done with instruments such as the amblyoscopes or the prism stereoscopes. In most cases the prescribing of prisms is as valuable as the use of these instruments. The exception to this rule is that patients with slight heterophorias, accommodative disturbances and reading defects benefit more by fusion exercises.

The following defects are the ones which are most successfully treated by fusion exercises:

1. Accommodative esotropia.
2. Deviations of fifteen degrees or less.
3. Postoperative deviations — especially residual esotropia, exotropia, or hypertropia.

4. Dissociated vertical divergence.
5. Exotropia of 5Δ to 10Δ resulting from a convergence insufficiency
6. Reading disturbances in elderly adults without severe motor disturbances.
7. Hysterical amblyopia or motor insufficiencies.

Fusion exercises are not a cure-all and should not be attempted in every case of squint and especially in patients with fixed constant anomalous correspondence.

Surgery. — As has been previously suggested, surgery should be utilized when mechanical defects in the extraocular muscles are found. These are rarely present in children. Before the author considers using surgery for patients with exotropia he must know the history, the types of treatment, and the type of squint.

If nonsurgical treatment has not been adequate in the case of a child then surgical treatment is undertaken. Surgery, moreover, is suggested if the patient is ten years of age or older, if the patient does not cooperate in wearing his glasses or using atropine, or will not attempt fusion training.

Ordinarily the surgical treatment of children with squint is necessary in approximately half of the cases.

It is a pleasure to thank Drs. Richard Gamble and Douglas Buchannon for their help and criticism during preparation of this paper.

Most of our cases of active pulmonary tuberculosis in years to come will develop from the group of school children who are reactors to the tuberculin test today. It is important to stress that all such reactors should be carefully watched, X-rayed annually and, wherever possible, the source of infection traced to prevent further spread of the disease. When an individual reacts to tuberculin, two important facts are immediately established: (1) the individual is at least a potential case of clinical tuberculosis; and (2) there has been a source of infection which may be sought among contacts. Lewis S. Jordan, M.D., Journal-Lancet, April, 1945.

We heard about the tipsy pre-med the other night who called up Dr. Wasserman of national fame and when the good doctor answered the phone our inebriated friend said, "Hello, is this Dr. Wasserman?" The voice said, "Yes." Our friend asked, "Are you positive?"

Columbia Jester

FIND DRUG MAY BE BENEFICIAL IN TREATMENT OF LEUKEMIA

Colchicine, a drug derived from the seed of the meadow saffron flower which grows abundantly in Europe and North Africa, has been found to have a beneficial effect in the treatment of acute myelogenous leukemia, a highly fatal disease.

W. Harding Kneedler, M.D., of Philadelphia, writing in the September 22 issue of *The Journal of the American Medical Association,* says that while no conclusions can be drawn as yet regarding the degree of beneficial effect of colchicine in this type of leukemia, "further trial of the drug for the condition seems justified."

Leukemia is a fatal disease characterized by the presence in the blood of numerous white cells, many of which are immature. The cause is unknown. In the acute type, ulcerative inflammation of the mouth or throat often marks the onset. Hemorrhages are common.

In the case reported by Dr. Kneedler in *The Journal,* colchicine was given in tablet form three times a day. The progress of the disease soon became less rapid, then improved. After losing 58 pounds, the woman patient showed a progressive gain in weight and strength. Transfusions were unnecessary for an eight month period.

After suffering several hemorrhages, the patient finally died.

Commenting on the treatment, Dr. Kneedler said that "colchicine was continued through the course of the disease, certainly without harmful effect and perhaps with actual though temporary benefit." He urged additional investigation.

Dr. Kneedler reported that Dr. O. H. Perry Pepper, also of Philadelphia, tried the drug in two cases of acute leukemia. It had no apparent effect in one case, but in the other there was complete halting of development for a while. "When relapse occurred the drug was resumed, but the further course of the disease was as would have been expected without the drug," he said.

The person who realizes that he has tuberculosis is more likely to take better care of himself and be more on guard against spreading his infection than if he is ignorant of the fact that he has the disease. John L. Rice, M.D., N. Y. State Jour. of Med., Feb. 1945.

Physical Medicine Abstracts

John S. Coulter, M.D.

COMBINED TREATMENT OF RHIZOMELIC SPONDYLOSIS

(Marie-Strumpell Arthritis)

Orthopedic, Roentgen Ray and Physical Therapy
Lenox D. Baker, M.D., Durham, N. C.

In ARCHIVES OF PHYSICAL MEDICINE, 26;7;394
July, 1945

Rhizomelic spondylosis, as the name implies, is a disease of the spine and root joints.

As a rule no corrective measures are attempted until all studies are completed and roentgen ray therapy has been given. The ray therapy gives early alleviation of pain with relief of muscle spasm and allows more rapid and less painful correction of the deformities. On relief of symptoms or after completion of one series of roentgen ray treatments as outlined in chart 4, corrective measures are started and physical therapy measures are begun. If any real benefit is to be derived from physical therapy measures, the patient must be relaxed and comfortable during the treatment. The patient with Marie-Strumpell arthritis usually has fixed deformities and is difficult to handle on the ordinary treatment table, especially when in the prone position. It was found that an operating table head rest, which is adjustable in all directions and which has attached shoulder supports, could be used to advantage in overcoming this difficulty.

Exercise equipment which was designed to aid in the correction of contractures in the anterior portion of the shoulder girdle, the thoracic cage and the abdominal wall and to help in developing the posterior shoulder girdle muscles and the thoracic bundles of the sacrospinalis muscle. In using the apparatus the patient stands against the wall pad and fixes the pelvis with the gluteal and lower abdominal muscles. The body strap is fitted snugly across the back and acts as a fulcrum over which the hyperextension forces act to correct the flexion deformity of the spine and to increase the excursion of the thoracic cage.

As the statistics show, the best results are obtained in the early stage of the disease. Experience with the combined therapy indicates that better results are obtained if the patient is hospitalized until full correction of the deformities is obtained and early signs of return of normal muscle power have appeared.

ELECTROSHOCK THERAPY IN PREGNANT MENTAL PATIENTS

Phillip Polatin, M.D., and Paul Hoch, M.D.,
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(From the Department of Psychiatry, the New York State Psychiatric Institute and Hospital)

In NEW YORK STATE JOURNAL OF MEDICINE, 45;14;1563
July 15, 1945

Two pregnant patients with mental illness were treated with electroconvulsive therapy. One was three and a half months pregnant and the other seven months. There was no miscarriage or premature labor and no evidence of asphyxia of the children. Electroshock does not seem to have any clinical effect on the smooth muscle of the uterus.

BODY MECHANICS AND POSTURE

K. G. Hansson, M.D., New York

In THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 128;13;953
July 28, 1945

It may be said that physical laws applied to our body mechanics give the answer to the question if posture is related to physical health. Even mental health is affected by posture. There are many clinical evidences for the effect of poor body mechanics and health.

In congenital torticollis that has persisted for several years the child gets into the habit of photographing his surroundings on a certain field of the retina. The consciousness of such pictures is related to the child's appreciation of his position to his surroundings. Geotropic reflexes are built up which give the child the impression of being straight when his head is actually crooked, and vice versa. Therefore the cutting of the shortened sternocleidomastoid muscle and the shortened cervical fascia is only the beginning of the treatment.

The lateral curvature of the spine of the idiopathic type should be treated as a postural deformity, and symmetrical exercises should be instituted and carried on till the patient reaches at least his sixteenth year. Special attention to the patient's general health, as indicated by his vital capacity, is most important.

The use of postural exercises in low back pain has been confused a great deal. The confusion is due to the fact that the same exercises have been prescribed for all pathologic conditions in the lower part of the back. It should be emphasized that the exercises should be specific and should be based on the pathologic changes present. Dealings with low back patients are facilitated by the following clinical classification:

However, overwhelming evidence has been presented by Pemberton, Swain and others that the arthritic patient must be taught the proper use of his body as a whole as well as the various joints. Chronically ill patients may be much improved by instruction in body mechanics. Many can be helped by special substitution movements or mass movement exercises.

Visceroptosis has received much attention from the point of view of body mechanics. Rest, support, diet and the proper instruction in posture and proper postural function are generally accepted now as the foundation for the management of these patients.

Much of our training of spastic hemiplegia depends on the application of body mechanics.

Brachial neuritis, the scalenus anticus syndrome or the cervical rib syndrome are often postural in origin and can be relieved by correcting the position of spine, head and scapulas.

PERIPHERAL NERVE INJURIES

Major Frank H. Mayfield, MC, AUS, Cincinnati, Ohio

In THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY, 44;3;275
March, 1945

RECONDITIONING

Rehabilitation must begin at the time of injury by preventing deformity and fixation of joints. Fractures of bones which require fixation in plaster, in association with nerve injury, are common. However, few require that the finger joints be encased, and this should be avoided. The patient should be instructed to use the unparalyzed hand for passive exercise of the paralyzed part. We have just completed the review of 100 cases of injury to one or more of the major nerve trunks of the hand. In 20 patients of this group, disabling stiffness of the finger joints existed. An analysis of their case histories made it clear that only one important principle of treatment had been violated; namely, they had not been instructed and required to passively exercise the paralyzed extremity.

Passive exercise to the foot is best applied by walking — all patients who can support themselves are fitted with appropriate splints and required to walk. We are convinced that passive exercise supersedes all other forms of physical therapy.

SPLINTS

It is imperative that patients wear appropriate splints to prevent overstretching of paralyzed muscles, and contractures of unparalyzed muscles. An elastic cock-up splint which was developed at Percy Jones Hospital is used for radial palsy. The wire drop-foot brace is used for peroneal paralysis. The airplane splint is worn by all cases with deltoid paralysis. There is no satisfactory splint for median and ulnar palsies. Full leg braces with knee drop locks are used for femoral palsies.

VISUAL EXERCISES IN OPHTHALMOLOGY

Joseph I. Pascal, M.D., New York

In ARCHIVES OF OPHTHALMOLOGY, 33;6;480
June, 1945

All are familiar with exercises which are used to develop and improve central macular vision. It is generally agreed that these exercises do not increase macular acuity in the physiologic sense. The improvement in vision which results in a great many cases is most likely due to an intensification of the psychic phase of the act of seeing. As Dr. Lancaster has so aptly put it in a recent article, "seeing is only half ocular — the other half is cerebral."

Now and then one reads in the lay, and sometimes in the professional, press of eye exercises consisting of wall to wall and floor to ceiling movements. The author thinks such exercises are senseless, for these movements are constantly being made in the ordinary course of daily use of the eyes. What is needed are movements which are not ordinarily made — and these are primarily forced duction or vergence movements in which the eyes are made to move in opposite directions. These exercises build up reserve power, but they are not muscle exercises. They are, rather, procedures for developing smooth neuromuscular pathways, probably akin to conditioned reflexes.

PAINFUL SHOULDER FOLLOWING CORONARY THROMBOSIS

Jackson E. Kress, M.D. and James R. McVay, Jr., M.D.

In THE GUTHRIE CLINIC BULLETIN, 15;1;22
July, 1945

In the cases reviewed by Howard and by Boas and Levy, local physiotherapeutic measures, such as massage, heat and passive and active motion, were found to be effective. In our present series, such measures were followed by cure in three cases after a term interval of from four to ten months; improvement in two, and no change in one. Edeiken and Wolferth, on the other hand, stated that local therapy was ineffectual in their cases but it will be remembered that those cases resembled causalgia and not periarthritis and, as such, probably represent a minority of the cases of shoulder pain following coronary thrombosis reported in the literature. This also applies to those few cases which were relieved by Libman's maneuver or strong pressure over a sensitive point along the brachial plexus on the affected side. Askey, whose cases resembled periarthritis, stated that various types of treatment seemed to have little or no effect and that the process seemed to be self-limited. This view was also advanced by Lippman in his study of periarthritis in general. Thus, it would appear that it is impossible to evaluate the effect of local measures on this condition until further controlled studies are undertaken.

CAUSALGIC STATES IN PEACE AND WAR

Geza de Takats, M.D., Chicago

In THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 128;10;703
July 7, 1945

There is an urgent need for the redefinition of causalgia. Burning pain associated with edema, glossy skin and a local rise in temperature is well known to follow certain partial injuries of the major nerve trunks. This group requires less attention because it is readily recognized and because its existence is not contested since the classic description of Weir Mitchell. Far more important, however, is another large group in which the origin and level of sensory stimulation is not frankly obvious. Such patients are frequently misunderstood or discredited but should be differentiated from patients suffering from purely psychogenic disorders, which occur after trauma following industrial accidents or war injuries.

It is well to look on the sensory pathways as being susceptible of stimulation at any level.

The causalgic state is due to a chronic irritation of sensory pathways producing cutaneous hyperalgesia, burning pain and a local increase in blood flow. Three sensory levels, a peripheral, a spinal and a cortical, can be clinically recognized. The lesion becomes more and more intractable the higher it ascends. In the first stage local infiltration and block of the paravertebral sympathetic nerves are effective. At the second level anterolateral chordotomy has been most helpful. The treatment of the third stage with cerebral tractotomies or removal of the sensory cortex is still in its infancy. Early diagnosis and immediate treatment saves much suffering and eliminates permanent disability. The true hysterical lesion shows no vasomotor changes except those due to immobility.

PHYSIOTHERAPY IN THE POST-OPERATIVE TREATMENT OF GYNAECOLOGICAL CONDITIONS

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In THE BRITISH JOURNAL OF PHYSICAL MEDICINE AND INDUSTRIAL HYGIENE, 8;3;82
May-June, 1945

(1) Treatment after abdominal operations

This should be begun on the day after the operation, and may be summarized as under:

(a) Teach upper chest and costal breathing

(b) Give active foot rolling followed by foot bending and stretching, each about 20 times.

Surgical opinions differ as to the advisability of active foot movements at this early stage, but experience of a large number of cases indicates that they may be given safely and advantageously.

(c) Gentle kneading of the calf muscles and quadriceps contractions may be added to the foot movements. Daily treatment continues until the clips are out, when abdominal and gluteal contractions are added. Exercises such as (i) pressing the thighs together with the legs crossed and (ii) gluteal contractions with outward rotations of the hips, are given for the pelvic floor and abdominal muscles.

(d) At this stage the patient may be rolled on to her side and gentle kneading given over the lumbar and sacro-iliac areas. After the stitches are out a graduated scheme of exercises is introduced, until the patient is finally prepared for getting up by means of foot and leg and abdominal and back exercises, performed in the sitting position with her knees flexed over the side of the bed.

(e) Two or three days later, when the patient has become accustomed to sitting in a chair, trunk exercises such as side bendings and rotations are begun.

(f) The patient is taught to control the tilt of the pelvis while sitting and then in the standing position. The treatment should not be terminated until the patient walks normally and is so accustomed to correct posture that she is conscious at once of any deviation from it.

(2) Treatment after correction of prolapse

Although the physiotherapy is much the same as that outlined for the abdominal operation patients, it cannot be begun so soon, except for the breathing exercises and foot movements.

THE MANAGEMENT OF RHEUMATOID ARTHRITIS

Richard J. Stevens, M.D., Huntington, West Virginia

In THE WEST VIRGINIA MEDICAL JOURNAL, 41;7;192
June, 1945

1. Rest: Rest in bed obviously is essential throughout the acute and subacute phases of arthritis, systemic rest on every hand being considered the most useful single basic factor in treating this disease. In securing local rest for joints, splints of various sorts often are very helpful since they relieve pain and relax spastic muscles, aid in preventing or overcoming contractures, and hasten the absorption of edema and effusion.

2. Analgesics: Analgesics for pain and discomfort consist chiefly of the salicylates.

3. Physical Therapy: Heat is an indispensable aid in the treatment of arthritis. Local applications of heat in any form provides temporary comfort. Wet dressings in acute cases are usually more soothing. Dry heat is more easily used in the form of an electric baker or an electric light cradle. Baking should be given in half hour to one hour sessions twice daily. Diathermy is similarly administered and is only palliative. Ultraviolet radiation with full body exposure is merely a valuable aid in general tonic therapy. Fever therapy provides transient relief of symptoms, especially after the acute state has passed. Generally, results of this procedure have been disappointing. Since it is felt that fever need not be raised above 103 F. to give beneficial results, intra-venous typhoid vaccine usually suffices. Histamine and mecholyl iontophoresis may be of value in treatment to produce temporary improvements; mild fever treatments produce the same results. X-ray therapy has been advocated, but due to conflicting reports its value is uncertain at present.

Massage is helpful if given gently and by a skilled physiotherapist. If used in acute cases it must be with utmost care.

Industrial Health

Committee On Industrial Health — Jos. H. Chivers, Chm., 836 S. Michigan Ave., Chicago 5, Frank P. Hammond, H. A. Vonachen, R. I. Barickman, C. O. Sappington, Milton H. Kronenberg.

OCCUPATIONAL DERMATITIS*

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The principles of diagnosis and prevention of occupational dermatitis have been firmly established by many workers in the field, notably Dr. Louis Schwartz, Medical Director of the Dermatoses Investigations Sections of the U. S. Public Health Service. Before discussing diagnostic criteria it is necessary to have some basic conception of the types of etiological agents present in industry capable of producting dermatitis. Occupational dermatitis is dermatitis venenata, so-called "contact" dermatitis, and is caused by contact of a dermatitis-producing agent with the skin. These agents may be of three kinds:

1. Primary skin irritants: These will cause a dermatitis in everybody if they are permitted to act in sufficient concentration and for a long enough period of time.
2. Allergens: These agents produce dermatitis in a certain percentage of people after their skin has become sensitized. Hence they do not produce dermatitis at first contact but do so usually after a lapse of at least a five to seven day period or longer.
3. Substances which have the properties of both, that is, are primary skin irritants and also in a small percentage of people produce an allergic dermatitis. Two are especially notable in industry — chromic acid and formaldehyde.

*Originally presented at American Mutual Industrial Nurses' Conference in Philadelphia and published in Industrial Nursing, June, 1945.

DIAGNOSIS

The diagnostic criteria that may be used in deciding whether a dermatitis is occupational in origin are many, and all factors must be analyzed and correlated to arrive at a correct conclusion.

HISTORY

The history of the onset and course of the dermatitis is extremely important, especially its relation to employment. If a substance is a known primary skin irritant, the dermatitis may come on at any time after the beginning of employment. For instance, in a man with a thin, dry skin a dermatitis may appear within a day or two after the use of strong solvents such as the operation of cleaning parts in naphtha. On the other hand, if the individual is exposed only to an allergen, a lapse of at least five days must occur before the dermatitis will appear unless he has been previously sensitized by employment somewhere else.

It is therefore extremely important that all individuals concerned in the diagnosis of occupational dermatitis be acquainted with all chemicals used in the plant and know their nature as a skin irritant, that is, whether they are primary skin irritants, allergens, or possibly both. This function should be the special concern of both the safety man and the nurse and all knowledge should be made available to the doctor who is involved in diagnosing and treating the case.

If the patient has a previous history of similar episodes of skin rashes, it would make one tend to believe that the disease is not occupational. On the other hand, the occurence of a rash soon after going to work indicates strongly an occupational origin. If other workers are similarly affected, it strengthens the presumption

that a dermatitis-producing agent exists in the plant. However, when dealing with allergic substances, it is entirely possible for one workman in a large group to become ill where all others are unaffected.

SITE

The appearance of occupational dermatitis is always on the exposed parts. If in contact with a solid or a liquid, it is usually on the hands, forearms, or fingers; if a dust or vapor, on the face and other exposed parts, but the entire body may be affected if the clothes are permeable to the dust or vapor. It is extremely rare for dermatitis to appear away from the site of exposure except in the case of sensitizers, as these also usually start in the area which is directly exposed. However, all skin lesions may be spread to the rest of the body and secondary infection, such as follows scratching, may spread the disease from the exposed parts to others. Careful inquiry into the individual's work habits must be made to ascertain these facts. For instance, a dermatitis on the abdomen may very well be occupational if the bench is moist and saturates the worker's clothes with the solution as he leans against it. In one instance, a dermatitis about the ankles due to alkali was diagnosed as occupational in origin. It did not occur on the rest of the body as the man wore protective clothing but in his work habits was extremely careless and permitted the solution to drip on his trousers. It should also be noted that points of friction are very apt to be the special sites of appearance of the lesions; for instance, the ankles at the shoe tops, the wrists where gloves or sleeves rub against the skin, or the collar line at the neck.

THE APPEARANCE OF THE LESION

In only few instances does the lesion have a characteristic appearance in occupational dermatitis. Most of the primary irritants and allergens produce an acute eczematoid lesion which may go through the stages of erythema, papulation, vesiculation, crusting and eczema. However, in the cases of exposure to oil, a typical folliculitis will develop, especially around the hairy portions of the body which are exposed, such as the back of the hands and the forearms. Chlorinated compounds, both in cutting oils and in the special chlorowaxes, produce a characteristic rash with black heads, acne and cyst formation around the eyes, lobes of the ears, jaw and other portions of the body.

The lesion induced by fat solvents or dehydrating solutions such as lime is characterized by drying, fissuring and cracking of the skin. This may be complicated by secondary infection.

Another type of characteristic lesion is induced by pitch and other coal-tar derivatives, sunlight, etc. This lesion is an overgrowth of the keratin layer of the skin with the development of papillomas which may be benign or malignant. The relationship of these characteristic lesions to the etiologic agent should be constantly kept in mind in making a diagnosis of occupation disease.

COURSE OF THE DISEASE

The course of the disease is also of moment in deciding whether a disease is occupational or not. An occupational disease appears at work, usually improves away from work, and recurs upon return to work. It should be borne in mind that in the case of allergens, an individual may be so sensitized that by simply entering a building in which an allergic material is used a severe dermatitis may result. If the dermatitis does not heal within two months after removal from work, the suspicion should be entertained that it is not occupational in origin or that it is complicated by some other factors.

DIFFERENTIAL DIAGNOSIS

The differential diagnosis in some instances is rather easy, since there is not great likelihood of mistaking occupational dermatitis with the usual types of skin disease, such as seborrheic eczema, pityriasis rosea, etc. The difficult differential diagnosis occurs when the physician meets a dermatitis venenata and must decide whether it is occupational in origin or due to some non-industrial factor such as cosmetics, dyes in clothing or plant allergens. In these instances a patch test may be of great value. A positive patch test is helpful in deciding the diagnosis, but a negative patch test must be read with care, since a great many errors are possible, especially with industrial dermatitis-producing agents. Some of the difficulties are that the skin may be desensitized at the point selected for patch testing or that the concentrations used may not be the same as occurred occupationally or the actual irritant may not have been discovered. Also, it is impossible to reproduce exactly the conditions that exist at

work, such as friction, maceration, heat, etc.

Fungus disease complicates the diagnosis in many instances. It must be borne in mind, however, that an individual may have fungus disease and an occupational dermatitis at the same time. Skin reactions to extracts of the fungi when positive are not of great significance, since most individuals have some fungus disease. Negative reactions, however, are significant, since they indicate that the dermatitis in question is not fungoid. The "phytid" response on the hands to the presence of fungi elsewhere on the body must be borne in mind, since it often confuses the diagnosis.

PREVENTION

The principles of prevention of dermatitis are self-evident if one keeps in mind that we are dealing with contact dermatitis and the irritant or allergen produces the lesion by getting on the skin. The first principle, therefore, is *prevent the material from touching the skin.* The best, most efficient and least cumbersome method is the use of engineering control. Dust, gases, and fumes should be controlled by power ventilation. The placing of a baffle on a machine may prevent the oil from saturating the worker. Analysis of work habits is indicated, since many workers have an undue exposure from faulty or careless work methods. If engineering control or work methods are not feasible, protective clothing may be the answer to the prevention of dermatitis. Clothing must be adapted for the individual worker and should be selected from the standpoint of comfort, wearability, function and also style. The use of protective ointments is probably the most popular method to achieve the desired end, that is, preventing contact of the substance with the skin. When it is realized that in addition to affording protection a skin ointment must also be easily applied, not rubbed off during the work period and easily removed at the end of the work day, it will be realized that a perfect protective ointment is almost impossible. Some of them, however, are of value, but they should be the last method rather than the first one in prevention.

The second basic principle of prevention is *if the irritants reach the skin, wash them off.* Hence personal hygiene of the individual is very important. The use of harsh abrasives, solvents, and other skin irritants in removing the dermatitis-producing agents should be condemned. A good, mild soap with plenty of hot water liberally and frequently applied is still the best method of getting rid of skin contaminants. A program of education should be initiated by the plant medical and safety departments for instructing and supervising the worker in personal skin cleanliness. Sanitary facilities in the plant must be made attractive to invite their use, and sufficient time must be allotted or shifts so staggered that facilities will be used.

TREATMENT

Approach to the treatment of occupational dermatitis depends on two factors: (a) avoidance of further contact, and (b) control of symptoms. Occupational dermatitis is always due to contact with the skin of an external irritant or sensitizer. If repeated or continued contact is prevented, no further injury takes place, and the physiological processes of repair are usually sufficient to heal the lesion. Therefore the first step in treatment usually requires that the individual be removed from his job. In some instances, especially when the lesion is caused by contact with a sensitizer, it may be advisable to keep the worker on the job in order to permit him to "harden," that is become desensitized to the industrial irritant. This should be done with great care under the supervision of a doctor who has the opportunity of seeing the patient frequently. If this is attempted, the worker should be given maximum protection in the form of work clothes, medication and personal hygiene. Workers cannot "harden" to primary skin irritants, and exposure to these materials should be reduced to zero or the worker taken off the job.

The only treatment other than removal from contact is symptomatic to relieve the pain, swelling and itching which are frequent concomitants of the lesion. Only the mildest form of lotions, dressings or ointments should be used. In the acute state when symptoms are severe and the lesion is moist, wet dressings of Burow's solution or boric acid are efficacious, simple to apply and interfere least with the normal healing process. Calamine lotion without phenol may also be used. In the later stages when the lesion becomes dry and symptoms are not as severe boric acid ointment, zinc oxide ointment or calamine lotion may be tried. Strong lotions and

ointments may irritate the lesion and prolong it. If the lesion fails to heal under this treatment, expert care is indicated, and the patient should be referred to a dermatologist.

CORONARY OCCLUSION IN INDUSTRY*

Reluctance or refusal to employ patients with arteriosclerotic heart disease or those who have had myocardial infarction is the policy of many large industrial companies. Controversy, particularly legal, continues over the relationship of coronary occlusion to effort, even though a sizeable portion of medical opinion discounts a casual connection. At present, with industry utilizing every available worker to meet the demands of the armed forces, reconsideration of the matter is in order.

Not every patient recovers sufficiently to return to his job, but on the basis of the observation of 84 Kaiser shipyard employees with infarctions, 75% of whom were manual laborers, Eugene B. Levine, M.D., and Edward Phillips, M.D., of Oakland, Calif., have found that many were able to resume full activity without recurrence of symptoms. Comparative analysis of the records of all cases of coronary occlusion revealed that the incidence of heart failure, subsequent infarction or death is the same whether the individuals who recovered resumed work or not.

Arbitrary standards for permissable work are neither possible nor desirable. Some patients must be assigned to light tasks or to sedentary work, while others are capable of manual labor, the kind and amount limited only by the individual's cardiac reserve as shown by his ability to do the job without producing untoward symptoms. A patient who is improving symptomatically and is steadily approaching normal cardiac capacity will very likely be able to work eventually. Such persons should be returned to useful and productive positions in society as soon as compatible with safeguarding the employer's interest.

A patient symptomatically well, after a lapse of time sufficient for the formation of a firm scar, is ready to resume employment under adequate medical supervision. As a matter of common sense such a patient should not be placed in a position in which sudden failure of one man would endanger the lives and safety of others, or would cause harm to himself, either by fall or by loss of control of machinery.

Of the 84 patients studied, 8 died within four weeks of the first infarction and 20 others failed to return to work. Desire to return was evident in 19 of the 20 but was not fulfilled because of the deaths of 3, an unrelated fracture in 1, and cardiac disability in 15. Only 1 patient failed to report because of nonmedical reasons. Fifty-six patients were re-employed, but 26 were forced to give up work after varying periods: 15 because of cardiac disability, 5 because of second myocardial infarctions which were fatal in 2 instances, 1 because of death without coronary occlusion, and 5 for nonmedical reasons. The other 30 patients were still working at the end of the survey, which covered an average observation period of 11.7 months. Nineteen had returned to the same jobs held before illness — 15 doing manual labor and 4 sedentary work; 11 to jobs different from those held before infarction — 6 doing light physical work and 5 sedentary tasks.

Only 20 of the survivors became completely free of heart symptoms. Of the other 50, 23 had angina pectoris, 12 congestive failure, 13 mild angina pectoris as well as congestive failure, 1 a complete auriculoventricular block and 1 cerebral thrombosis. The last 2 did not return to work. Eleven of the patients with angina pectoris took jobs, but only 2 of the 12 with congestive failure resumed employment, although of 13 patients with mild angina pectoris and congestive failure 7 returned to work. In 20 cases, sequelae of angina pectoris, congestive failure, or both in mild degree, were compatible with continued employment.

More than a year after the first infarction, 32% of the patients who returned to jobs were still working. Eleven patients had 2 myocardial infarctions and 4 returned to their jobs after the second coronary occlusion. One had to stop working after almost a year but the other 3 were working at the end of the survey.

For one reason or another, the condition of 10 patients was not promptly diagnosed. All 10 worked through the critical period of coronary occlusion, each after taking less than a week off for the acute illness. Most of these patients did not consult a physician.

*Levine, E. B., and Phillips, E., Coronary Occlusion in Industry. Am. Heart J. 29; 588-597, 1945.

News of the State

PERSONALS · COMING EVENTS · MARRIAGES · DEATHS

ADAMS COUNTY

E. B. Montgomery of Quincy, who has practiced medicine longer than any physician in the state, was honored by the Kiwanis Club on September 10th. Doctor Montgomery has been in active practice 67 years and is still actively practicing his profession. He is the oldest member of the Adams County Medical Society, joining it in 1879 and has been a member of the Illinois State Medical Society longer than any physician in the state. Speakers at the luncheon were Doctor Harold Swanberg and Mr. Thomas A. Hendricks of the American Medical Association who spoke on "Postwar Medical Service."

BOONE COUNTY

Major Wesley B. Oliver of Belvidere has been discharged from the army after three years of service and is resuming practice in his former office. Doctor Oliver was awarded the Bronze Star Medal last fall by Gen. George S. Patton "for display of fine administrative ability, indefatigable energy and tireless devotion to duty, all of which were of inestimable value in the prompt and efficient evacuation of Third army casualties."

CHAMPAIGN COUNTY

James S. Mason of Urbana, Annie L. Zorger of Champaign, T. Lee Agnew of Ogden and F. S. Diller of Rantoul were presented awards for 50 years of active medical practice at the Champaign County Medical Society meeting of September 13th. Awards were presented by Andy Hall of Mount Vernon.

Lt. Col. James E. Blades of Sidney, after four years in service, has been released and has resumed his practice in Sidney.

CHRISTIAN COUNTY

Lt. Col. R. B. Siegert of Pana, former chief surgeon with the 96th Evacuation Hospital has returned to civilian practice and has reopened his office in Pana.

COOK COUNTY

Capt. Seymour Hershman, of Chicago, Medical Corps, 109th Evacuation Hospital, U. S. A. has been awarded the Bronze Star Medal "for meritorious service in connection with military operations against an enemy of the United States during the period July 17, 1944 to April 28, 1945. Capt. Hershman, serving as Assistant to Chief of Surgical Service, 109th Evacuation Hospital, distinguished himself by his outstanding performance of duty. The high degree of professional skill he displayed, his resourcefulness and loyal, untiring devotion to duty reflect great credit upon himself and the military service."

CLINICAL CONFERENCE

The Chicago Medical Society's Annual Clinical Conference will be held at the Palmer House, Chicago, March 5, 6, 7, 8, 1946. All physicians are invited to attend this Conference and hear the outstanding specialists from all sections of the country discuss subjects of major interest. Make your reservations early at the Hotel.

Lt. Col. James P. Grier, chief of surgery at Gardiner General Hospital, has been discharged and is returning to private practice in Evanston.

Major Samson D. Entin of Chicago has been awarded the Bronze Star Medal "for meritorious service with the 65th Inf. Division in France Germany, Austria for period March 5 to May 8, 1945."

Louis D. Boshes of Chicago, MC USNR has been promoted to Lt. Comdr.

Announcement has been made of the promotion to Captain of Ernest R. Blondis who formerly practiced in Lemont.

The Legion of Merit, recently awarded posthumously to Capt. Jerome D. Solomon, Army

Medical Corps, was presented on September 23rd to his parents. The ceremony was held at Thorne Hall, Northwestern University and speakers included Morris Fishbein and Karl A. Meyer. Captain Solomon died of typhus fever in Guinea in September, 1944. He was awarded the Legion of Merit, America's fourth highest honor, for singular devotion to duty in giving medical aid to men stricken with typhus while he himself was ill.

Louis B. Newman, Chicago, has been promoted to full Commander and will continue as Head of the Department of Physical Medicine and member of the Rehabilitation Board of the U. S. Naval Hospital, Seattle, Washington.

Capt. Carl H. Resnick, Chicago, has been decorated with the Bronze Star Medal for meritorious service in Italy, France and Germany from April 20, 1944 to March 3, 1945.

Capt. Max M. Bernstein of Chicago, a prisoner since the fall of Corregidor has been liberated from a Japanese camp. He formerly was resident physician at Cook County Hospital.

Bernard C. Roloff, welfare director for the Chicago Park District, has been appointed director of industrial programs for the Tuberculosis Institute of Chicago and Cook County.

Asa Bacon, who retired in 1941 after serving more than 30 years as superintendent of Presbyterian Hospital, died on September 11th in Dowagiac, Michigan, where he had made his home since his retirement. He was a former president of the American Hospital Association.

Ray E. Brown, former superintendent of the North Carolina Baptist Hospital, Winston-Salem, North Carolina, has been appointed assistant superintendent of the University of Chicago Clinics. He will be assistant to Doctor G. Otis Whitecotton, superintendent.

The army has announced the promotion from Major to Lt. Colonel of Ralph Hess Kunstadter of Chicago.

Mrs. Ben Humphries Gray has succeeded Audrey Hayden Gradle as Executive Secretary of the Illinois Society for the Prevention of Blindness.

Samuel M. Feinberg of Chicago, Chief of the Division of Allergy, Northwestern University Medical School was a member of the faculty presenting an Orientation Course in Clinical Allergy at the School of Medicine, University of Pittsburgh, in October, for veterans, service men and residents. The course is sponsored by the American Academy of Allergy.

The veteran 25th portable hospital, numbering many Chicagoans and downstate Illinoisans, jumped from ships to become the first American hospital in southern Japan. Every doctor but one is a Rush Medical College graduate. Major Frederick dePeyster of Winnetka is in command of the hospital which includes in its staff Captain Hugo Baum of Chicago and Captain Edward Murphy of Dixon.

Stewart C. Thomson on September 10 resumed his activities as assistant dean of the Loyola University School of Medicine. Dr. Thomson was recently released from service, after serving for the past seventeen months as chief of the collection branch in the medical intelligence division of the preventive medicine service and as the liaison officer between the Office of the Surgeon General and G-2, War Department General Staff.

An institute to apply the discoveries of atomic research to such problems as cancer, heredity and growing old has been established at the University of Chicago. Raymond E. Zirkle, Ph.D., Springfield, Ill., a botanist who has specialized in the effect of radiations on living organisms, will be in charge of the new department, the institute of radiobiology and biophysics. Members of the new institute will work in cooperation with the institute of nuclear studies. This arrangement is part of he university's plan to further fundamental research in fields which were kept secret or neglected during the war.

A special program will be held October 29 at the Chicago Lying-In Hospital to observe the fiftieth anniversary of its founding. The hospital was established in 1895 by Dr. Joseph B. De Lee. In addition to clinics being conducted by members of the staff, the following will participate: Dr. Frederick C. Irving, Boston, A Bood Bank for a Lying-In Hospital; Dr. Edwin C. Hamblen, Durham, N. C., Some Contributions of Endocrinology to Obstetrics and Gynecology; Dr. Norman F. Miller, Ann Arbor, Mich., Hysterectomy — Therapeutic Necessity or Surgical Racket?; Dr. Hendricus J. Stander, New York, Teaching of Obstetrices and Gynecology.

Clarence J. Zurfli has recently been promoted from Major to Lieut. Colonel. Col. Zurfli is attached to the 361st Station Hospital.

The 228th Station Hospital, Sherborne, England, after caring for 22,924 patients, thousands

of whom were battle casualties, has completed its work in England. Among those who helped in the operation of the hospital was Major Irving E. Steck. Major Steck was chief of the medical service.

Captain John M. Staron has recently returned from overseas duty and is now stationed at Schick General Hospital, Clinton, Iowa.

Lieut. Col. H. Ivan Sippy, formerly of the 13th General Hospital, was in October, 1944, appointed Chief of the Medical Service of the 248th General Hospital, at that time stationed in New Guinea. Since March, 1945, he has been serving as Commanding Officer of the unit, which is now established in the Manila Area.

Lt. Col. James J. Callahan formerly assigned to the 4th Service Command at Atlanta, Ga., was recently assigned to the Orthopedic Branch, Surgical Consultants Division, Office of the Surgeon General, Washington, D. C.

Lt. Col. Earle I. Greene has been awarded the Bronze Star for meritorious service in connection with military operations, as Chief of Surgical Service, 35th Station Hospital, European Theater of Operations from July 15, 1943 to May 8, 1945. During one emergency he personally operated on the more seriously wounded for seventy-two successive hours and saved many lives. Recently Col. Greene met his brother, Major Jos. M. Greene, in Paris, after not having seen each other for more than three years.

Capt. William H. Borkenhagen has been awarded the Bronze Star for meritorious service in connection with military operations against the enemy during the period from June 14, 1944 to April 17, 1945 in France, Belgium and Germany. Capt. Borkenhagen displayed expert surgical skill and mature judgment as battalion surgeon. Capt. Borkenhagen is attached to the 552nd Anti-Aircraft Artillery, Automatic Weapon Battalion.

Capt. Lawrence S. Mann returned to the United States after 18 months of service in the European area including England, France, Belgium, Holland and Germany. Attached to the 6th Engineer Special Brigade supporting the 29th Division of the 1st Army he was one of the first doctors to land in the invasion of Normandy.

Stephen A. Zieman,USNR has recently been promoted from Lt. Comdr. to Commander. Comdr. Zieman is Assistant Editor of the U. S. Naval Medical Bulletin, Bureau of Medicine and Surgery, Navy Department, Washington, D. C.

CRAWFORD COUNTY

The Crawford County Board of Supervisors recently unanimously adopted a resolution commending Dr. L. P. Sloan, Oblong, for his service as a Director of the Crawford County Sanatorium Board and requested the Chairman to reappoint Dr. Sloan for a term of three years.

The Crawford County Medical Society met on September 7th. The program was devoted to a discussion of the sulfa drugs. L. B. Highsmith read a paper on "Use of Sulfa Drugs in Treating Respiratory Diseases" and L. P. Sloan gave a paper on "Abuses of Sulfa Drugs in Treatment of All Diseases."

DE WITT COUNTY

Owen Nowlin of Farmer City has been promoted to a full Commander in the Navy and has been assigned to the Edenton Naval Air Station, Edenton, North Carolina.

Harmon D. Seeley of Clinton has been promoted to Major. He has been located at a hospital in Germany but recently was transferred to an evacuation hospital in France.

DU PAGE COUNTY

Clarence B. Wyngarden of Wheaton has been promoted from First Lieutenant to Captain at Camp Maxey, Texas. He served as surgeon at Wheaton College from 1939 to 1943 and at Williams Military Academy from 1941 to 1943.

HENRY COUNTY

The Kewanee Physicians Club has sponsored the examining of first grade pupils in the Kewanee public schools.

IROQUOIS COUNTY

J. M. Roberts, Watseka physician, has been promoted to Commander in the Navy. He is now the senior medical officer at the Naval Air Station in French Morocco.

JACKSON COUNTY

William T. Felts has reopened his office in Carbondale after serving three years with the U. S. Army Medical Corps.

JEFFERSON COUNTY

Col. Wilford F. Hall, son of Dr. and Mrs. Andy Hall of Mt. Vernon, has been assigned as headquarters surgeon of the 9th Air Force in the Army of Occupation in Germany. Colonel Hall is a graduate of Washington University School of Medicine, 1928 and in 1935 he was graduated as a flight surgeon at Randolph Field, Texas.

JO DAVIES COUNTY

Herbert Frederick Chwatal of Galena has been promoted to Lt. Colonel in the U. S. A. Medical Corps.

KANE COUNTY

Joel L. Deuterman, Elgin, has been advanced to the rank of Colonel at Madigan General Hospital, Fort Lewis, Washington.

KANKAKEE COUNTY

Chester A. Perrodin, formerly of Kankakee, a Lt. Comdr. MC USNR expects to be stationed in Shanghai and will leave from San Francisco in the near future. Comdr. Perrodin left Kankakee about a year ago to rest and get a "build-up" in Van Nuys, California, prior to applying for his commission.

LAKE COUNTY

Lt. Comdr. Aaron A. Topcik of Waukegan has been promoted to a full Commander in the USMC. He participated in the battle of Okinawa with the Marine Corps and is now stationed on Guam.

LA SALLE COUNTY

Major E. G. Barton of Streator has returned from overseas and will report to Camp Bowie, Texas, for reassignment. Major Barton has been in service three years and wears the ETO ribbon with two battle stars and a Bronze Star medal for heroism in the battle line in Alsace, France. He also wears the Combat Medics' Badge, awarded doctors in the front line trenches.

LEE COUNTY

For meritorious service and bravery, particularly in the 37th Division's campaign in Manila, Lt. Col. William T. Holladay, Dixon, has been awarded the Legion of Merit.

Clifford D. Hartman of Sublette, Lt. Comdr. in the Navy at the Naval Air Technical Training Center at Millington, Tennessee, has been visiting his family. When released from service, he will resume active practice of medicine in Sublette.

McLEAN COUNTY

C. R. Ahroon of Bloomington, Lt. Comdr. in the Navy, has had the unusual experience of performing an emergency appendectomy recently aboard a ship at sea, while a typhoon was in the offing. The sick bay on the ship is in the fantail. In heavy weather the up and down movement of the ship is nearly equal to its forward movement. It was under such conditions that Comdr. Ahroon had to perform the operation while the typhoon hit in full fury. The patient "weathered the storm."

MACON COUNTY

Maurice Murfin, son of Dr. Walter D. Murfin of Decatur and grandson of the late Dr. W. W. Murfin, has been released from military service and has become associated in surgery with Doctor Ciney Rich in Decatur.

MADISON COUNTY

William S. McGinnis of Alton, after three years' service in the Army Medical Corps, has been released from service and has returned to Alton to practice.

MERCER COUNTY

Lt. Col. Leon E. Robinson of Aledo, first Aledo physician to enter the armed forces in World War II and the first to return after service in the combat areas, has received his honorable discharge and is resuming practice in his home city.

MORGAN COUNTY

The Morgan County Medical Society held its first meeting of the season at Jacksonville on September 13. Dr. S. N. Clark spoke on "Functional Nervous Diseases" and case reports were given by Doctors Paul Allyn of Waverly, J. W. Martin of Murrayville and R. R. Jones of Winchester.

PEORIA COUNTY

James W. Sours of Peoria has been made a full Commander and is now serving on Okinawa at a hospital.

Walter W. King, Major USA Medical Corps has been awarded the Bronze Star medal at Winter General Hospital, Topeka, Kansas, where he is now stationed as chief of the surgical service. The citation accompanying the medal read: "For meritorious service in connection with military operations against the enemy as surgeon, general surgical team No. 5, third Auxiliary Surgical Group, from June 6, 1944, to October 16, 1944, in France and Belgium. Although the arrival of medical equipment and supplies were delayed during the landing of his surgical team upon the invasion beach on D-day, Major King, displaying outstanding initiative and marked professional ability, organized his group and gave immediate treatment to battle casualties. During subsequent operations, he displayed tireless effort and worked many hours each day to bring expert medical service to seriously wounded patients."

Honored guest at a dinner meeting of the Peoria Medical Society September 18th at the Pere Marquette Hotel, Peoria, Doctor Sandor Horwitz, district health officer who has prac-

ticed medicine for 50 years, was awarded a 50 year pin and certificate by the Illinois State Medical Society and presented with a scroll signed by members of the local society. Presentation of the pin and certificate for "continued practice in the medical society of Peoria county and the Illinois State Medical Society" was made by Doctor Charles P. Blair of Monmouth.

ROCK ISLAND COUNTY

Doctor Daniel Paul, Rock Island, has been named a director of the Rock Island Chamber of Commerce, representing the Rock Island County Medical Society.

VERMILION COUNTY

Lt. Comdr. Jean Moore of Danville has been promoted to the rank of full Commander and is now stationed at Greencastle, Indiana, where he is physician in charge of the V-12 Units at DePauw University, State Teachers College of Terre Haute, Wabash College and the Indiana School of Medicine and Dentistry.

ST. CLAIR COUNTY

The five sons of Doctor and Mrs. Charles E. Eisele, 3806 Caseyville Avenue, East St. Louis, now in the army follow the professional footsteps of their father. They are Capt. Owen J. Eisele who is in Czechoslovakia; Capt. Adrean S. Eisele, Commander of Medical Detachment of 748th Military Police; Capt. Vincent G. Eisele, with the 92nd Field Hospital on Luzon; 1st Lt. Matthew B. Eisele, Medical reserve officer and at present resident physician in OB and GYN. at St. Mary's Hospital in Clayton, Mo.; Private Justin Eisele, 3rd year pre-medic student at St. Louis University with the signal corps unit in the Philippines. Capt. Owen Eisele, former staff physician at St. Mary's Hopital, East St. Louis has just been awarded the Bronze Star Medal for heroic service in connection with military operations against the enemy in Germany April 2, 1945.

A joint meeting of the St. Clair County Medical Society and the Illinois Heart Association was held at St. Mary's Hospital, East St. Louis on October 4th. A cardiac clinic was held in the afternoon by Chauncey C. Maher of Chicago and Harry A. Durkin of Peoria, President of the Illinois Heart Association. Doctor Maher gave the address of the evening on "Treatment of Cardiac Failure with Edema."

STEPHENSON COUNTY

Major Everett W. Brott of Lena has been awarded the Bronze Star Medal for meritorious service in connection with military operations against the Germans.

TAZEWELL COUNTY

Lt. Comdr. L. F. Teter of Pekin, has gone to San Francisco to resume his duties after a visit with his family.

VERMILION COUNTY

Physical examinations for pupils of the first and fifth grades in the grade schools and freshmen students in Danville High School by members of the Vermilion County Medical Society are under way.

WILLIAMSON COUNTY

Capt. M. M. May of Marion has been awarded the Bronze Star Medal and the Meritorious Service Unit Plaque, Captain May has been stationed in Balzano, Italy, but is expecting to return shortly and to resume his practice in Marion.

DEATHS

William S. Brown, Elgin; University of Illinois College of Medicine, 1894. Practiced medicine in Elgin since 1896 and veteran of World War I. For many years, chief of staff of Sherman Hospital. Died of heart attack, aged 77, August 17th.

Fletcher L. Crocker, Pontiac; Miami Medical College, Cincinnati, Ohio, 1891. Practiced medicine in Pontiac for 40 years. Died at St. James Hospital, Pontiac, August 31st, aged 79, following an illness of 2 days.

Charles Johnston Davis, Deerfield; University of Illinois College of Medicine, 1902. Veteran of World War I; had practiced in Deerfield over 40 years specializing in radiology. Died in his home Sept. 15th, aged 71.

Walter J. Fahrner, Joliet; Northwestern University Medical School, 1905; practiced medicine in Joliet since graduation; member of one of Joliet's oldest practicing medical families. Died following an operation in St. Joseph's Hospital Sept. 4th at the age of 64.

William Arvel Gott, Peoria; Chicago Homeopathic Medical College, 1901. Practiced medicine in Peoria 25 years. Served in the medical corps in World War I. Died following a brief illness Sept. 18th, aged 69.

Francis Marion Hiller, Carterville; St. Louis College of Physicians and Surgeons, 1909. Died of a heart attack while attending a County Fair, Aug. 31st, aged 66.

Grace Frith Jerger, (not in active practice,) Chicago; University of Illinois College of Medicine, 1904. Died Sept. 18th at the age of 67 years.

Lieut. Victor Herbert Karpass, Chicago; Univer-

sity of Illinois College of Medicine, Chicago, 1935; member of the American Medical Association and the Missouri State Medical Association; interned at St. Mary's Hospital in Minneapolis and the Woodlawn Hospital in Chicago; served a residency at the Anna State Hospital in Anna, Ill.; began active duty as a first lieutenant in the medical corps, Army of the United States, on Feb. 24, 1942; awarded posthumously the Distinguished Service Cross for heroism; killed in action in Africa, Nov. 8, 1942, aged 33.

Henry Randal Kenny, Golf; Trinity College, Dublin, Ireland, 1909. Was Chicago surgeon for 35 years; formerly chief of staff of John B. Murphy Hospital and staff member of Alexian Brothers, Columbus and Illinois Masonic Hospitals. Died, aged 59, on Sept. 9th.

Arthur C. Kleutgen, Chicago; Northwestern University Medical School, 1902. Was Captain in the medical corps in World War I. Formerly instructor in medicine, physical diagnosis at Northwestern University Medical School, associate professor of medicine at Loyola. Died, aged 66, September 13th at Woodlawn Hospital.

Burdette E. La Due, Sterling, retired; Rush Medical College, 1885. Had practiced medicine at Plano, Tampico, Ottawa. Died at the age of 82 on Sept. 9th.

Robert Antoine Le Tourneau, Chicago; Northwestern University Medical School, 1895. On staff of Jackson Park Hospital; physician and surgeon in Chicago for 50 years. Died Aug. 29th, aged 83.

Lt. Cmdr. Thomas W. Miller, USNR, formerly of Alton; St. Louis University School of Medicine, 1927. Survived four naval attacks against the Japs. On leave in San Francisco was killed in an automobile accident August 29th. He was 43 years of age.

Willis Moore, Vermont, retired; Northwestern University Medical School, 1890. Practiced in Chicago for many years. Died at the age of 82 on Aug. 17th.

Walter Preston Scott, Lexington; Keokuk Medical College, 1898. Died at Mennonite Hospital, Bloomington, Sept. 16th; had suffered a broken leg a week before death. He was 80 years old.

Eugene Adelbert Sullivan, Amboy; University of Illinois College of Medicine, 1899. Had practiced medicine in Amboy since graduation. Died Sept. 15th, aged 69.

James Wilson Wallace, Aledo; Northwestern University Medical School, 1906; postgraduate work in New York and Chicago. Had practiced medicine in Aledo since graduation. Died August 25th following injuries suffered when he stumbled and fell on the steps of his office. He was 64 years old.

CANCER OUTLOOK BETTER

The mortality from cancer, particularly among women, is beginning to come under control. This is indicated by the experience among the many millions of Industrial policyholders of the Metropolitan Life Insurance Company and is confirmed by other sources. In the past decade, for example, the age-adjusted death rate from cancer among insured white females dropped 11 percent at ages 1 to 74 years; virtually every important age group shared in the improvement. The current mortality from the disease among women in the broad age range 35 to 64 is the lowest in a third of a century, having dropped by one fifth during that period.

Among white male policyholders, too, a favorable indication is noted. The distinctly upward trend which had been manifested for many years has been stemmed. In fact, during the past decade, at no age beyond 25 years has the cancer death rate among these men shown any increase, and at some age periods the mortality has tended downward recently.

That the organized movement to control cancer is bearing fruit is evident from the fact that people, and more especially women, are seeking diagnosis and treatment earlier in the course of the disease, when the chances of cure are best. For example, among the patients at the cancer clinics in Massachusetts, the average delay between first symptoms and visit to physician was reduced from somewhat more than six months in the period 1927 to 1935, to 3.3 months in 1943.

To give further impetus to this movement, the Metropolitan Life Insurance Company is conducting a special campaign during October. At that time, the Company's more than 20,000 Field Representatives, in cooperation in many communities with official and voluntary agencies, will distribute to practicing physicians a special packet of new information on cancer. Included will be the American Cancer Society's booklet, "The General Practitioner and the Cancer Patient"; a reprint of recent studies of cancer mortality prepared by the statisticians of the Metropolitan; a reproduction of the Company's educational advertisement on cancer, "Cancer Has Its Hopeful Side!," appearing during October in National magazines with a combined circulation of about 30,000,000 readers; and a copy of the Company's new leaflet for laymen, "There is Something *You* Can Do About Cancer." As part of this "message of hope about cancer," Metropolitan Field Representatives will endeavor to place the latter publication in more than one million homes. In addition, these representatives will place in prominent locations in their communities 6,000 window cards urging early diagnosis of cancer.

Prompt diagnosis of tuberculosis is important to the patient, family and community. Every suspected case should be cleared of suspicion as quickly as possible by being proved innocent or guilty of harboring the disease. The Modern Attack on Tuberculosis, Henry D. Chadwick, M.D., and Alton S. Pope, M.D.



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OSMOPAK, as a profound depleting agent, is ideally suited as medical treatment in simple cervicitis. The use of OSMOPAK, by tampon, immediately after cautery will definitely give a quicker and cleaner healing, will effect a better slough.[1] The product may be used in all trimesters of pregnancy without untoward effect.

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1 Klein, H. L., J. Mo. State M A., April 1939
*T M Reg. U. S. Pat. Off.

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The changes which have occurred in the national dietary during the war period, especially the increased consumption of carbohydrates, lend new importance to dietary supplementation with B vitamins. To assure better utilization of a diet high in carbohydrates, and to prevent or correct deficiencies of vitamin B complex factors, NOVIPLEX provides a rational, adequately potent formula.

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Each capsule of Noviplex contains:

Thiamine hydrochloride (B_1) (1 mg.).....333 U.S.P. Units
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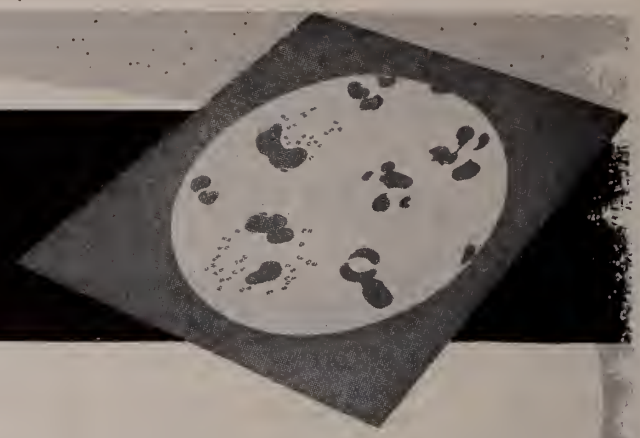
Tablets of 0.1 Gm. (1½ grains), tubes of 15 (plain) and bottles of 25, 100, 500 and 1000 (plain or sugar-coated). Also tablets of 0.05 Gm. (¾ grain), bottles of 50, 500 and 1000 (plain). Ampuls of 0.2 Gm., boxes of 5.

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In the Rapid Eradication of GONORRHEA



THOUGH the sulfonamides presented a signal advancement in the treatment of gonorrhea, many published reports indicate that penicillin is the therapeutic agent of choice for three potent reasons. First, *efficacy:* penicillin proves effective in virtually all instances. Second, *safety:* penicillin is practically nontoxic. Third, *brevity of treatment:* in the majority of cases, definite cure can be effected in 24 to 48 hours.

Studies at an Army Station Hospital showed that most sulfonamide-resistant gonococci are fully susceptible to penicillin; that penicillin resistance is difficult to establish.

Frisch, A. W.; Behr, B.; Edwards, R. B., and Edwards, M. W., Am. J. Syph., Gonor., & Ven. Dis. 28:527 (Sept.) 1944.

From a study of 109 patients, the conclusion is drawn that penicillin effectively eradicates chemoresistant gonorrhea in the female.

Greenblatt, R. B., and Street, A. R., J. A. M. A. 126:161 (Sept. 16) 1944.

At a U. S. Naval Hospital, 200 cases of sulfonamide-resistant gonorrhea treated with penicillin, showed no toxic reactions; all returned to duty in one-third of the time previously required.

Scarcello, N. S., New England J. Med. 231:609 (Nov. 2) 1944.

"In the Technical Bulletin of Medicine, No. 26, recently issued by the War Department, penicillin is stated to be the drug choice in the treatment of gonorrhea."

J. A. M. A. 126:575 (Oct. 28) 1944.

191 consecutive cases of sulfonamide-resistant gonorrhea responded dramatically to penicillin.

Wigh, R., and Geer, G. I. Jr., J. Maine M. A. 35:207 (Nov.) 1944.

No toxic effects were observed in a series of sulfonamide-resistant gonorrhea of the female treated with penicillin. As compared to hyperpyrexia, penicillin treatment "is incomparably easier, simpler, safer, cheaper, and just as effective."

Barringer, E. D.; Strauss, H., and Horowitz, E. A., N. Y. State J. Med. 45:52 (Jan. 1) 1944.

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For therapy in the physician's office and in the patient's home, the Combination Package of Penicillin-C.S.C. deserves the physician's preference. It provides two rubber-stoppered, aluminum-sealed, serum-type, 20 cc.-size vials, one containing 100,000 Oxford Units of Penicillin-C.S.C., the other 20 cc. of sterile, pyrogen-free physiologic salt solution. Penicillin-C.S.C. is of high purity, as indicated by the small amount of substance required to present 100,000 Oxford Units.

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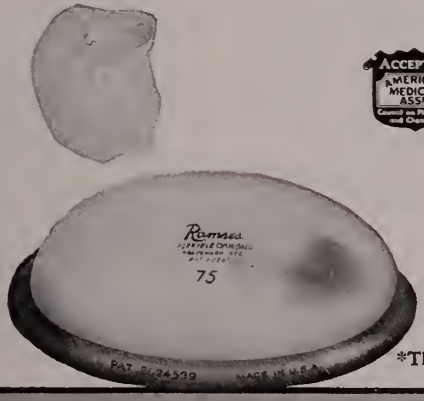


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Salinger, S.: Arch. Otolaryng. 4:40, 324,
noting Box, H.E.H.: M. J. Austrolio 2:126.

Benzedrine Inhaler, N.N.R., produces a shrinkage of the nasal mucosa equal to, or greater than, that produced by ephedrine — and approximately 17% more lasting. It is, consequently, strikingly effective in relieving headache, pressure pain, "stuffiness" and other unpleasant sinusitis symptoms. Each Benzedrine Inhaler is packed with racemic amphetamine, S.K.F., 200 mg.; menthol, 10 mg.; and aromatics.
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a better means of nasal medication

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FOR MOTHER—a generous supply of all essential vitamins, well above the minimum daily requirements.

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THE effectiveness of Mercurochrome has been demonstrated by more than twenty years of extensive clinical use. For professional convenience Mercurochrome is supplied in four forms—Aqueous Solution in Applicator Bottles for the treatment of minor wounds, Surgical Solution for preoperative skin disinfection, Tablets and Powder from which solutions of any desired concentration may readily be prepared.

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is economical because stock solutions may be dispensed quickly and at low cost. Stock solutions keep indefinitely.

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P. R. N.

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Peoria, Ill.

THE MINK LAKE TRAIL

Beside a crystal lake there lies a forest dense
Of tall and close-grown poplar, birch and pine,
Sepulchral shadows there enshrowd its silent depths
And pungent forest odors are like wine.

Within these depths there winds a meagre, unmarked trail
Between the trees, o'er rocks and muskeg dank,
And cushioned deep on either side is mottled moss
And multi-colored toadstools broad and rank.

At times the trail is lost on floor of barren rock,
Above in Gothic arch the branches close,
A hallowed spot is Nature's huge cathedral nave
Where lies eternal peace and calm repose.

The only signs of life are flash of flitting birds,
A recent track of moose upon the trail,
An awkward porcupine, a glimpse of doe and fawn
All else the endless struggle to prevail.

The bald and bare volcanic knobs all aeons old,
And trod no doubt by prehistoric man,
Have stood against erosion for a million years
And countless millions more will be their span.

Here, thickly grown, are somber trunks of evergreens
And poplars gray and birches chaste and white
No spread of branch, no width of trunk but tall and lean
Their growth is wholly upward toward the light.

Across their shallow roots a deep ancestral mold
Gives sustenance to all things now alive,
Decomposition of the generations past
Makes possible their efforts to survive.

Yet in this doleful symphony of life and death
Two themes of gaity and cheer abound,
The merry scarlet partridge berries under foot
The laughing flecks of sunshine on the ground.

A wild, archaic region, solemn and majestic,
Where only strong survive, by Nature's plan,
And midst this stately, mighty, prehistoric grandeur
There walks a puny, upstart thing called man.

(*Continued on page* 54)

Must

INCREASED IRRITATION

follow

INCREASED SMOKING?

PEOPLE are smoking heavily . . . far more than ever before. To *minimize* nose and throat irritation due to smoking, may we suggest the cigarette *proved** definitely and measurably less irritating . . . PHILIP MORRIS.

This proof of PHILIP MORRIS superiority is dependent *not only* upon laboratory evidence, but on clinical observation as well. Research was conducted *not by anonymous investigators, but by recognized authorities* . . . and published in leading medical journals.

The fact is PHILIP MORRIS advantages result directly from a *distinctive method of manufacture* described in published reports.

**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32, 241; N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.*

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TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend — COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

P. R. N. (Continued)

WORK

Where could I look for interest more than in my daily work?
'Tis vastly more intriguing than the things that we call play;
My work, in contemplation,
Provides such fascination,
That I can fold my hand and sit and look at it all day.

FUNNY FASHIONS

I've long since ceased to laugh at girls with spike heeled shoes,
Or lean and skinny men in dinner coats;
The long or short of women's skirts does not amuse,
Nor summer furs all snug about their throats.

I chuckle gently, though, at men with gaudy spats,
And smile at dresses wholly minus backs,
I giggle some at all those things that folks call hats,
And pudgy gray haired women wearing slacks.

I really laugh aloud at hair dyed carrot red,
A wholly futile effort to look cute,
A scant toupee is just funny as, 'tis said,
A flabby, fat man in a bathing suit.

But the one thing providing longest, loudest laughs,
In all the realm of fashions outdoor sports,
Revealing as it does such shapeless thighs and calfs,
Is large and portly females wearing shorts.

Samuel Johnson was once rebuked by a friend, who said, "Johnson, I tried to be a philosopher at one time, but failed because cheerfulness kept creeping in."

CHEERFULNESS CREPT IN

I have studied philosophy deeply,
A most gloomy and murky of tasks,
For it seems to hold mankind most cheaply,
It gives little for all that he asks.
Countless volumes I read most astounding,
I absorbed much of wisdom therein,
At philosophy I was dumbfounding,
'Till cheerfulness crept in.

I have read theological teaching,
All its creeds and its dogmas perused,
Found the only one right is now preaching,
All the others are vilely abused.
I have heard all their arguments bitter,
If I do not agree 'tis a sin,
At theology I am a quitter,
For cheerfulness crept in.

(*Continued on page* 56)

THREE FOLD HELP

in NUTRITIONAL HYPOCHROMIC ANEMIA

IRON...LIVER EXTRACT B-COMPLEX FACTORS

Scientifically combined and processed to supplement nutrition where iron deficiency and B-complex avitaminosis coexist.

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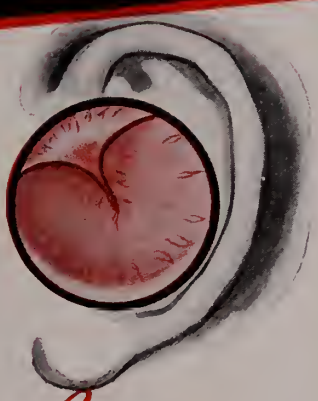
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Symptoms

Pain, fever, edema, leucocytosis, sense of fullness and impaired hearing.

Treatment

Relief of pain and inflammation—*Auralgan.*

Action

Decongestant, analgesic, bacteriostatic.



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Persistent discharge, often foul smelling, usually no toxemia, no pain, no fever.

Treatment

Otosmosan.

Formula

Sulfathiazole carbamide 20% in glycerol (Doho).

Action

Deodorizes the discharge, liquifies unhealthy granulations, bacteriostatic, permits normal epithelialization.

Scientific data and reprints of clinical studies reporting upon the use of Otosmosan available on request.

Complimentary quantities for clinical trial

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New York 13, N. Y. • Montreal • London

P. R. N. (Continued)

I have read much of history's pages,
Filled with bloodshed and rancor and hate,
For each hero produced through the ages
A full million have gone to their fate.
It was dismal, depressing, misleading,
With its battles and slaughter and din,
So I've stopped all my history reading,
For cheerfulness crept in.

My philosophy is joviality,
My theology is geniality,
And my history, jocularity
Since cheerfulness crept in.

I merrily, gleefully look at life,
Facetiously, mirthfully watch its strife,
For happiness lightens its burdens rife
Since cheerfulness crept in.

Sophistes the Seer sayeth, "My son, keep ever in thy mind that authority changeth not a man. It only taketh off his mask."

Give me liberty to know, to think, to believe, and to utter freely, according to conscience, above all other liberties.

John Milton

No girl worth her salt is going to turn down nursing as a career because of its risks to life or health; rather is she going to be attracted to it for this very reason — in that matter-of-fact manner in which the young woman of today does what she deems to be her duty. But this in no way exonerates those in authority from doing their utmost to reduce the occupational hazards to a minimum. Tuberculous morbidity in young women is still excessively high. There should be no complacency if in nurses it is not even higher than among other young women. One should expect a much lower morbidity in nurses, since they could be under excellent supervision, could have ideal diet and could live in an ideal environment if nurses' meals and homes were properly planned. Marc Daniels, M.D., NAPT Bull., April, 1945.

Tuberculosis still ranks as our seventh or eighth cause of death. The major problem which confronts us, in this case, is early diagnosis; but this term no longer means the diagnosis of clinical disease by fever and a cough and loss of weight. It means diagnosis before clinical disease occurs at all — diagnosis through the magic of the X-ray. In many individuals, tuberculosis can be arrested even after clinical symptoms have appeared. In other instances, it is by that time too late. The keystone of our program must be the discovery of early lesions in the lung at a time when the keenest diagnostician with his stethoscope can observe no clinical abnormality. C. E. A. Winslow, Survey Graphic, April, 1945.

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Favorite Laxative Solution

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Alpha-estradiol, the true follicular hormone in tablets

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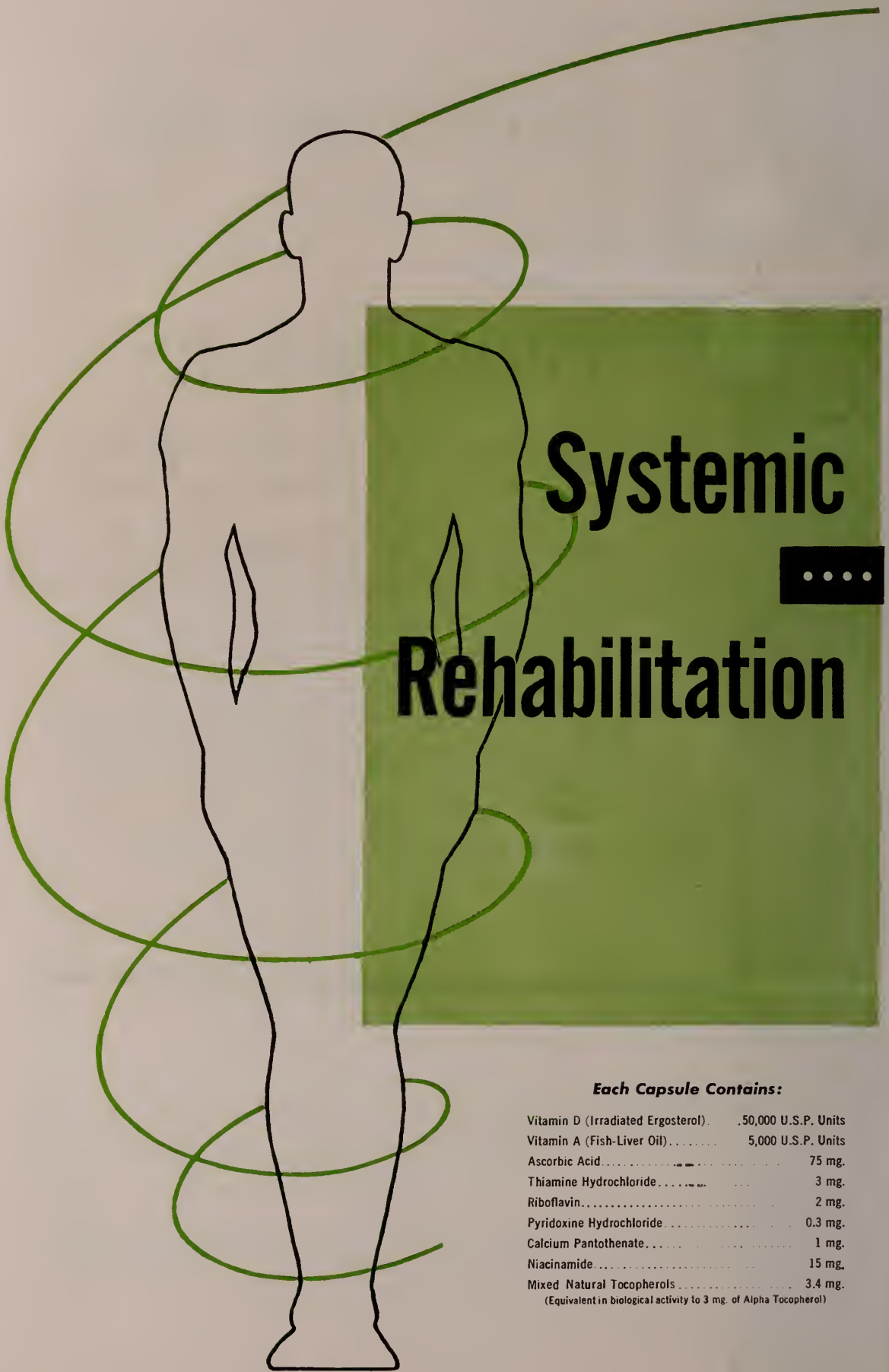
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Systemic
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Each Capsule Contains:

Vitamin D (Irradiated Ergosterol)	50,000 U.S.P. Units
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Ascorbic Acid	75 mg.
Thiamine Hydrochloride	3 mg.
Riboflavin	2 mg.
Pyridoxine Hydrochloride	0.3 mg.
Calcium Pantothenate	1 mg.
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Mixed Natural Tocopherols	3.4 mg.

(Equivalent in biological activity to 3 mg. of Alpha Tocopherol)



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Recognition of the systemic nature of chronic arthritis and the multiphasic involvement it engenders has led to the present method of treating the arthritic patient as a whole, not merely the involved joints.

A complete therapeutic program is needed—one which includes optimal nutrition, orthopedic measures, elimination of foci of infection, physical therapy, supervised exercise, mental and physical rest, and correction of disturbed physiologic functions.

Darthronol, by the pharmacodynamic and nutritional actions of its nine constituents, not only exerts a beneficial influence on the disturbed locomotor structures but in addition proves of value in the elimination of many systemic disturbances encountered in the arthritic syndrome. Comprehensive literature on request.

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Book Reviews

DISEASES OF THE BREAST: Diagnosis, Pathology, Treatment. By Charles F. Geschickter, M.A., M.D., Lieut. Commander, Medical Corps, United States Naval Reserve; Director of the Francis P. Garvan Cancer Research Laboratory; Pathologist, St. Agnes Hospital, Baltimore. With a special Section on Treatment in Collaboration with Murray M. Copeland, A.B., M.D., F.A.C.S., Instructor in Surgery, Johns Hopkins Medical School, Visiting Surgeon and Assistant Oncologist, University Hospital, University of Maryland Medical School, Visiting Oncologist, Baltimore City Hospitals. 593 illustrations. Second Edition. J. B. Lippincott Company, Philadelphia and London. Price $12.00.

The author has assembled the present knowledge on the anatomy, physiology and pathology of the human breast from its embryonic development through to senescence. He has correlated its development and functional activities to the stimuli received by the endocrine system at different stages in the life cycle of the individual. By so doing he has shown the underlying basis for the pathological changes seen in various forms of mammary disease and neoplastic growth. Excellent descriptions of chronic cystic mastitis, mastodynia, adenosis or Schimmelbusch's disease, and the histo-pathology is correlated to similar changes produced by stimulation of the breast by various hormones.

Disturbances of the breast by infections and changes caused by pregnancy and lactation are thoroughly covered and the relation of these physiological states to malignancy of the breast is well handled.

A wealth of statistical material on the various forms of breast pathology is presented which makes the volume valuable as a reference work.

Benign and malignant tumors, their diagnosis and treatment are exhaustively covered in a clear and concise manner. The operative and roentgenological aspects are thoroughly discussed and beautifully illustrated. Plastic operations on the breast are also described.

An analysis of the experimental data upon which rests the concept of the endocrine basis of the production of mammary tumors is made. The author is careful to point out the difficulty of transposing information obtained experimentally on laboratory animals to other species including man.

(*Continued on page* 62)

Pan-Nutron Super Capules

Improved

Actual Therapy VS Prophylaxis

A POLYVITAMIN OF EXCEPTIONALLY HIGH POTENCY FOR ACTUAL THERAPY

NEW FORMULA

Vitamin A-5000 U.S.P. XII Units
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Vitamin C— 100 Milligrams
Vitamin B_1—10 Milligrams
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Niacinamide 50 Milligrams

The amount of vitamins supplying the basic requirements and the amount needed for actual therapy of a specific vitamin deficiency are two different problems. Only through intensive and persistent therapy can satisfactory results be obtained. Pan-Nutron Super Capules provide therapeutic amounts of all essential vitamins.

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BOOK REVIEWS (Continued)

The book is profusely illustrated, has a wealth of bibliographic reference, and is very well organized making it excellent material for the busy practitioner as well as for undergraduate and postgraduate instruction.

F.H.F.

DIETOTHERAPY; Clinical Application of Modern Nutrition. Edited by Michael G. Wohl, M.D., Associate Professor of Medicine, Temple University School of Medicine; Chairman, Advisory Committee on Nutrition, Philadelphia Department of Public Health. With a Foreword by Russell M. Wilder, M.D., Ph.D., Professor of Medicine and Chief of the Department of Medicine, Mayo Foundation; Member of the Committee on Medicine and Subcommittee on Medical Nutrition, Medical Sciences Division, National Research Council. W. B. Saunders Company, Philadelphia and London, 1945. Price $10.00.

The author endeavors in this book to stress the importance of nutrition in the treatment of disease as well as for the maintenance of normal health. The book is intended for the student, dietician and the practitioner to give sound knowledge on the current advances in dietotherapy. With a foreword by Russell M. Wilder, more than fifty contributors have joined with the author in the preparation of the book.

It is stressed that reliance for nutrition is placed primarily on foods, although in many diets some concentrated nutrients must be added to care for possible nutritional inadequacies. In cases of malnutrition not only vitamins are needed, but also minerals in amounts not contained in food alone. Iron, calcium and amino acids are among these special requirements in addition to vitamins in concentrated form.

Normal nutrition is stressed in the first part of the book, beginning with the normal diet, the role of water, carbohydrates, fat and protein considered in individual chapters. The vitamins, as essential in normal diets, are as would be expected, given much consideration. Part two gives careful consideration to nutrition in periods of physiological stress, as in pregnancy, in infants and children, in the aged, and in relation to infection and immunity.

Part three discusses nutrition in disease, including pernicious anemia and other closely related anemias. The subject of allergy from foods is likewise given careful consideration. Likewise dietary considerations, both pre and post operative for surgical patients, are well covered in the book. An interesting chapter is devoted to amino acids as protein nourishment, and is of much interest today.

This book with 1029 pages and with 93 illustrations, should fill a need in the average medical library, and should indeed be of much value to physicians, dieticians and students alike.



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PEDIATRIC X-RAY DIAGNOSIS; A Textbook for Students and Practitioners of Pediatrics, Surgery and Radiology; By John Caffey, A.B., M.D., Associate Professor of Pediatrics, College of Physicians and Surgeons, Columbia University; Associate Pediatrician and Roentgenologist, Babies Hospital and Vanderbilt Clinic, New York City; Consulting Pediatrician, Grasslands Hospital, Westchester County, N. Y., and St. John's Hospital, Yonkers, N. Y. The Year Book Publishers, Inc., Chicago. 1945. Price $12.50.

SYNOPSIS OF GENITOURINARY DISEASE: By Austin I. Dodson, M.D., F.A.C.S., Richmond, Virginia. Professor of Genitourinary Surgery, Medical College of Virginia; Genitourinary Surgeon to the Hospital Division, Medical College of Virginia; Genitourinary Surgeon to Crippled Children's Hospital; Urologist to St. Elizabeth's Hospital; Urologist to St. Luke's Hospital and McGuire Clinic. Fourth Edition. With 112 Illustrations. St. Louis, The C. V. Mosby Company, 1945. Price $3.50.

ESSENTIALS OF CLINICAL ALLERGY: By Samuel J. Taub, M.D., Professor of Medicine, Cook County Graduate School of Medicine. Attending Physician in Medicine, Cook County Hospital. Fellow of the American Academy of Allergy. Formerly Assistant Professor of Medicine, Rush Medical College, of the University of Chicago. Baltimore, The Williams and Wilkins Company, 1945. Price $3.00.

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Herbert N. Vermilye, M.D., of Forest Hills, N. Y., in the September 22 issue of *The Journal of the American Medical Association,* reports the successful treatment of more than 200 patients with the inhaled drug known as "aerosol penicillin."

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Another advantage is that inhalation of penicillin mist introduces the drug directly into the site of bacterial invasion and produces a high local concentration at the point of the infection. Dr. Vermilye emphasizes the fact that aerosol

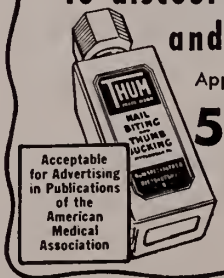
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PENICILLIN (Continued)

penicillin was repeatedly found to control infections of the upper respiratory tract which were not cured by penicillin injections or which relapsed after its use.

The author stated that in an epidemic of an unclassified virus disease of the upper respiratory tract during the late winter months of the past year, aerosol penicillin was used to good effect. "While the virus infection itself was probably not influenced by the drug," the doctor pointed out, "the patients frequently were definitely benefited because secondary bacterial infections did not arise to complicate the original disease. Many patients appeared to be well after treatment for one or two days although penicillin was continued for about five days. Perhaps one factor in the rapid recoveries was the general feeling of well being and the increased appetite which commonly accompany aerosol penicillin treatment. Similarly the duration of colds has been repeatedly shortened because of the elimination of secondary bacterial invasions."

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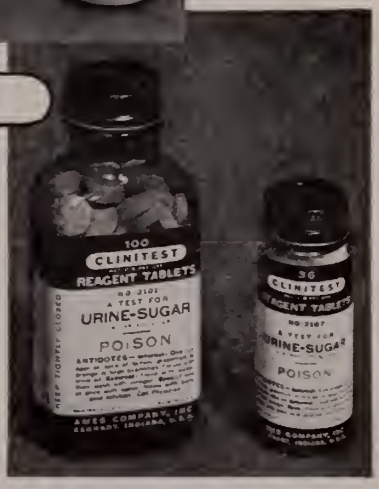


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REPORT DRUG THIOURACIL NOW CURES THYROID GLAND INFLAMMATION

Two Seattle phyicians report that the drug thiouracil, which previously has been used in toxic goiter, has been employed successfully in the cure of thyroiditis — a general inflammation of the entire thyroid gland.

In *The Journal of the American Medical Association* for September 22, Dr. Brien T. King and Dr. Leo J. Rosellini state that out of 11 cases diagnosed as thyroiditis and treated with thiouracil, eight were symptom free in one week, and in all the gland enlargement completely disappeared.

Previous treatment of this thyroid inflammation has included iodine, rest, hot applications, ice bags and x-ray. The sulfonamide drugs have been tried, but so far they have been of little benefit. Prior to September 1944, the only treatment that definitely seemed to shorten the course of the disease was x-rays.

In describing the disease, the authors stated that in a considerable percentage of all cases there had been a history of recent mouth or throat infection. The disease is usually of sudden onset, occurring in a previously normal gland or one slightly enlarged. They emphasize the fact that they have not seen it develop in a previously existing goiter of any type. It is associated with slight to moderate enlargement of the thyroid gland, which is usually quite tender and painful.

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The source of the spread of tuberculosis in a community is the sum total of all open cases of the disease in the locality. Consequently the greater the opportunities for exposure to open cases the higher the prevalence of tuberculosis morbidity and mortality in a community. The greater prevalence of tuberculosis in the more densely populated areas is reflected in the higher rates for children in these localities. J. Yerushalmy, Ph.D. & C. Silverman, M.D., Am. Rev. Tbc., May, 1945.

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Rachitic changes were present as late as the fourteenth year, and the incidence was higher among children dying from acute disease than in those dying of chronic disease.

The authors conclude, "We doubt if slight degrees of rickets, such as we found in many of our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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VICTOR LOAN

The ILLINOIS Medical Journal

VOL. 60 ✳ NO. 5

November, 1945

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✦

Orbital Proptosis

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OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY



Stimulative Therapy in Reproductive System Dysfunction

GONADOPHYSIN

Zondek has summed up the influence of the anterior pituitary upon sex functions in these words:

"Without the anterior lobe hormone, no gonad activity! no ovulation! no sex rhythm! Without the anterior lobe, atrophy of the sex mechanism! Without the anterior lobe, no conception!"*

Where supplementation of deficient anterior pituitary folliele stimulating and luteinizing hormones is indicated, Gonadophysin presents these fractions prepared from fresh sheep glands in stable powder form. Solution for injection is easily and quickly prepared by adding the sterile diluting solution which accompanies each ampul.

Gonadophysin is being used with definite therapeutic effect in developmental disturbances of the reproductive system resulting from gonadotropic hormone deficiency, the management of menstrual disorders referrable to ovarian dysfunction, and in functional menopausal states.

Supplied in packages of three serum-type ampuls (500 Rat Units each) and three 5 cc. ampuls of dissolving solution.

Gonadophysin is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois

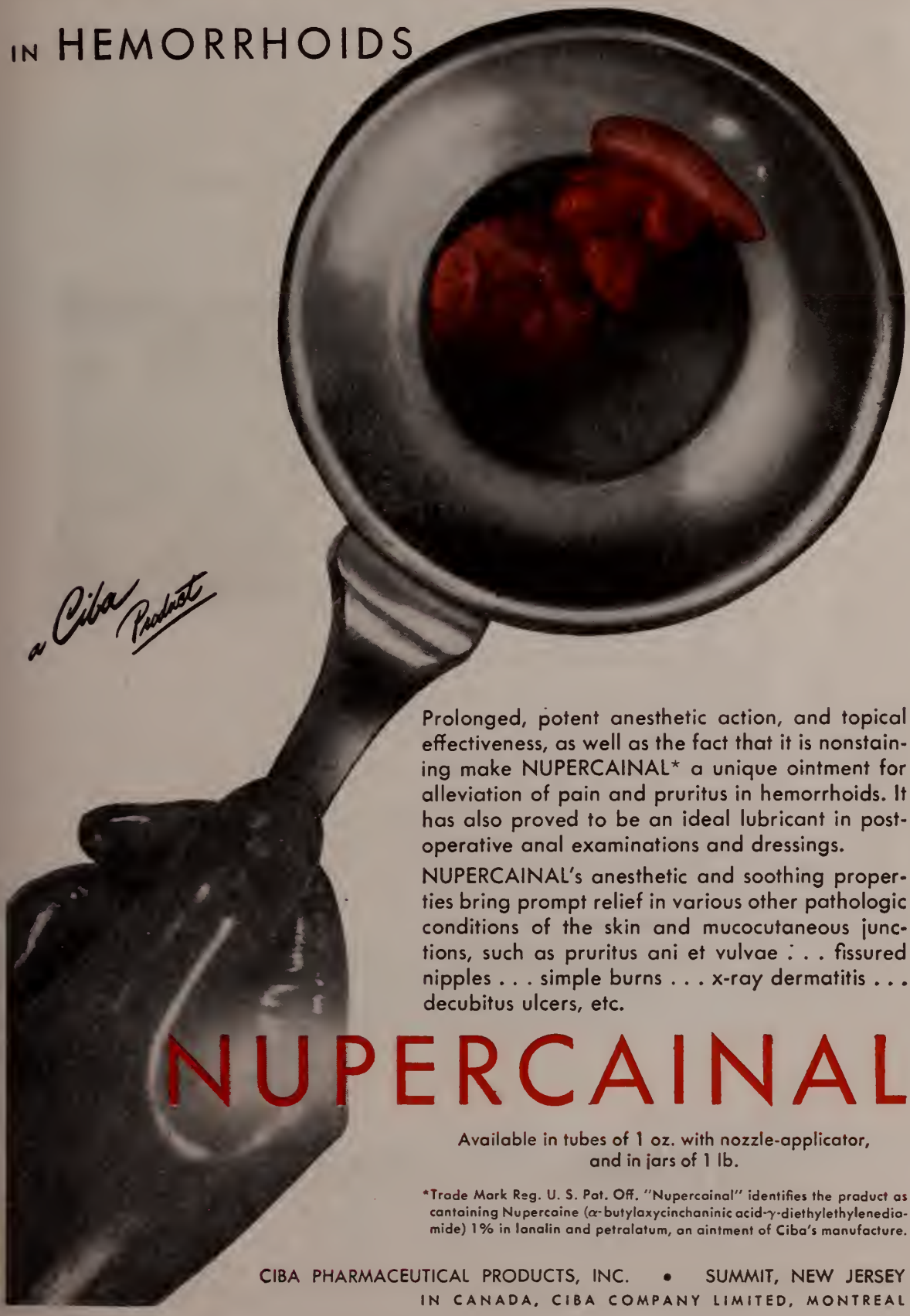
*Synopsis of Materia Medica, Toxicology, and Pharmacology, Davison, F. R.: Hormones, St. Louis, The C. V. Mosby Company, 1942, p. 582.

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

Entered as Second-Class Matter July 21, 1919, at the Post Office, Oak Park, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate of postage provided for in Section 1102, Act of October 8, 1917, authorized July 15, 1918. Office of Publications, 715 Lake Street, Oak Park, Ill.

FOR RELIEF OF PAIN AND ITCHING IN HEMORRHOIDS



a Ciba Product

Prolonged, potent anesthetic action, and topical effectiveness, as well as the fact that it is nonstaining make NUPERCAINAL* a unique ointment for alleviation of pain and pruritus in hemorrhoids. It has also proved to be an ideal lubricant in postoperative anal examinations and dressings.

NUPERCAINAL's anesthetic and soothing properties bring prompt relief in various other pathologic conditions of the skin and mucocutaneous junctions, such as pruritus ani et vulvae . . . fissured nipples . . . simple burns . . . x-ray dermatitis . . . decubitus ulcers, etc.

NUPERCAINAL

Available in tubes of 1 oz. with nozzle-applicator, and in jars of 1 lb.

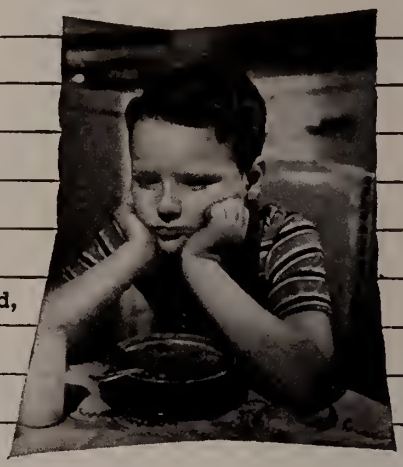
*Trade Mark Reg. U. S. Pat. Off. "Nupercainal" identifies the praduct as cantaining Nupercaine (α-butylaxycinchaninic acid-γ-diethylethylenediamide) 1% in lanalin and petralatum, an aintment of Ciba's manufacture.

CIBA PHARMACEUTICAL PRODUCTS, INC. • SUMMIT, NEW JERSEY
IN CANADA, CIBA COMPANY LIMITED, MONTREAL

Commonest pediatric problem:



"My child won't eat"



Even though a child may be undernourished, his appetite often fails. To combat anorexia caused by a lack of important B vitamins, pediatricians increasingly prescribe 'Ryzamin-B' No. 2. Containing the natural B complex as a concentrate of oryza sativa (American rice) polishings, 'Ryzamin-B' No. 2 also supplies potent synthetic B factors. Children enjoy this rich, honey-like, tasty B complex preparation taken directly from the special measuring spoon, as a delicious spread when mixed with jam or peanut butter, or dissolved in milk, fruit juices, favorite beverages. The doctor often solves his commonest pediatric problem with 'Ryzamin-B' No. 2.

Tubes of 2 oz and bottles of 8 oz Each gram contains: Vitamin B_1 (Thiamine Hydrochloride) 1 mgm (333 U.S.P. Units); Vitamin B_2 (Riboflavin) 0.67 mgm; Nicotinamide 6.7 mgm. and other factors of the B complex Gram measuring spoon with each packing.

'RYZAMIN-B' BRAND RICE ~~POLISHINGS~~ CONCENTRATE **No. 2**

WITH ADDED THIAMINE HYDROCHLORIDE, RIBOFLAVIN, NICOTINAMIDE

'Ryzamin-B' reg. trademark

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CHECK...!

✔ *"Premarin" is an orally active estrogen of proved clinical effectiveness. The rapidly expanding bibliography provides ample evidence of its value in clinical practice.*

✔ *While "Premarin" is one of the most highly potent estrogens available, it is exceptionally well tolerated, and untoward effects are rarely noted.*

✔ *"Premarin" is derived exclusively from natural sources, and is earning increasing recognition for its desirable property of imparting a feeling of well-being.*

✔ *"Premarin" provides a convenient form of therapy for both physician and patient. It is available in tablet form in two potencies: No. 866 (yellow tablet) for the more severe deficiency, and No. 867, Half-Strength (red tablet), where a milder estrogen is required.*

Standardized by colorimetric and biological methods and supplied with the approval of the Research Institute of Endocrinology, McGill University.



"Premarin" TABLETS

ACCEPTED AMERICAN MEDICAL ASSN.

CONJUGATED ESTROGENS (equine)

No. 866, in bottles of 20, 100 and 1000 tablets; No. 867 (Half-Strength) in bottles of 100 and 1000 tablets

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Ayerst

A New and Definite Advance

IN THE TREATMENT OF

IRON-DEFICIENCY ANEMIAS

White's

MOL-IRON

TABLETS

A *specially processed*, co-precipitated complex of molybdenum oxide (3 mg.) and ferrous sulfate (195 mg.), White's Mol-Iron is a new, highly effective, hemopoietic agent that has unique therapeutic advantages in iron-deficiency anemias.

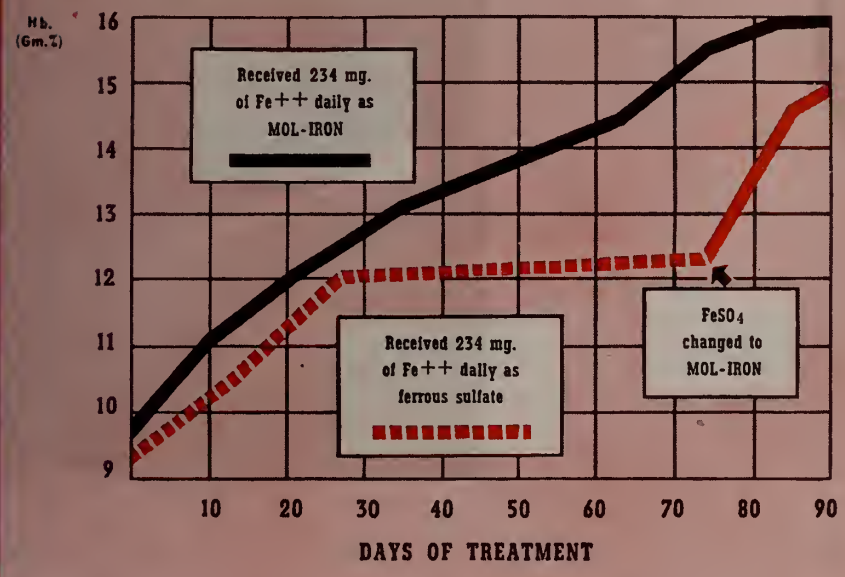
Available clinical evidence indicates that Mol-Iron effects approximately:

1. **100% GREATER THERAPEUTIC UTILIZATION OF IRON,** and

2. **100% MORE RAPID REGENERATION** of hemoglobin than does ferrous sulfate, with

3. **NOTABLE ABSENCE OF GASTRO-INTESTINAL REACTIONS**—even among patients exhibiting such untoward symptoms during administration of other commonly used iron preparations.

TYPICAL HEMOGLOBIN RESPONSE TO MOL-IRON AND TO FERROUS SULFATE IN PREGNANT WOMEN WITH IRON-DEFICIENCY ANEMIAS



The therapeutically superior effect of Mol-Iron in human beings is well demonstrated in the accompanying graph which illustrates the rate of hemoglobin regeneration in females during the last half of pregnancy and having approximately the same degree of iron-deficiency anemia. Results in this series of cases are typical of those observed in an evaluation* of Mol-Iron in a series of pregnant women with hypochromic anemia.

May we suggest that you make a comparable evaluation of Mol-Iron with your presently preferred therapeutic iron compound.

DOSAGE: One to two tablets three times daily after meals.

SUPPLIED: in bottles of 100.

*Neary, E. R., Preliminary Evaluation of Molybdenum-Iron Complex in Hypochromic Anemias of Pregnancy, to be published.

PHARMACEUTICAL White MANUFACTURERS

HOW YOUR PATIENT CAN OBTAIN

IN NASAL AND SINUS INFECTIONS



WRONG

When the patient instills nasal medication in an upright position, it runs along the floor of the nose, and does not reach many of the engorged areas where it is most needed.



RIGHT

But when the patient assumes a dependent, head-low posture, Paredrine-Sulfathiazole Suspension spreads rapidly and evenly, effecting prompt vasoconstriction and prolonged bacteriostasis *precisely* where they are needed most.

PAREDRINE-SULFAT

VASOCONSTRICTION

IN

MINUTES

BACTERIOSTASIS

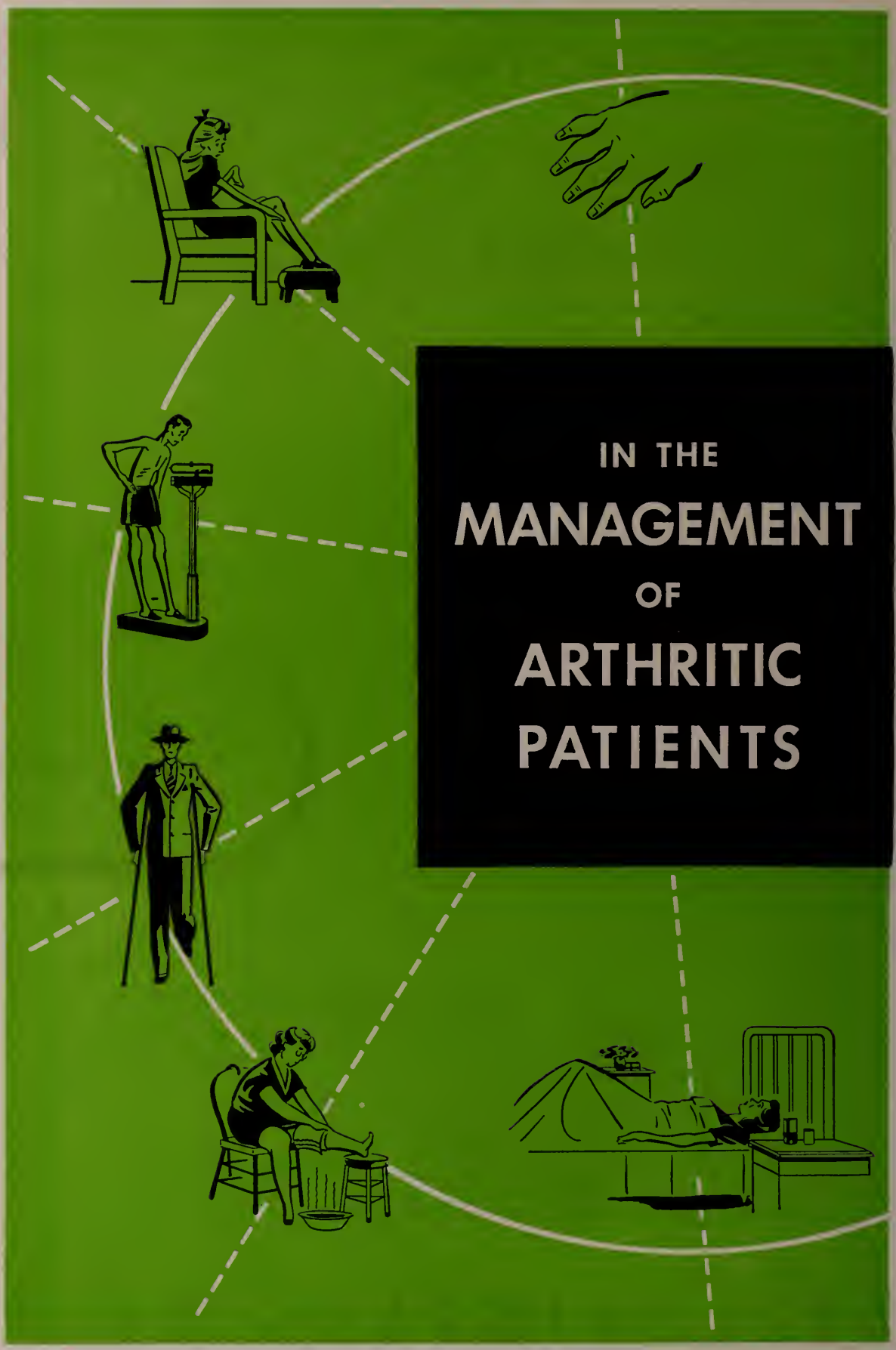
FOR

HOURS

IN
SORE THROAT

So that Paredrine-Sulfathiazole
ıspension will remain on ınfected areas hour after hour, and thus main-
in its maximum bacteriostatic action, the sore throat patient should be
dvised: (1) to instill the Suspension intranasally *after* eating and just
fore retiring; (2) to refrain from drinking fluids as long as possible after
ach instillation, and (3) to reduce nose-blowing and throat-clearing to a
ınimum. Smith, Kline & French Laboratories, Philadelphia, Pa.

AZOLE SUSPENSION



IN THE MANAGEMENT OF ARTHRITIC PATIENTS

* In the 1943 edition of *Nutrition and Diet in Health and Disease*, McLester emphasizes the importance of large amounts of all the essential vitamins in the treatment of chronic rheumatoid arthritis. He states that "Vitamins in abundance should be provided."

* *"Vitamins in abundance should be provided"*



Most rheumatologists recognize this need for all the vitamins, in addition to any specific requirement, in the management of the arthritides. Clinical investigations emphasize the systemic nature of chronic arthritis and reveal that better results were obtained when in addition to massive doses of vitamin D adequate amounts of other vitamins were supplied.

For the physician's convenience in prescribing these vitamins, and to assure greater patient cooperation, Darthronol supplies in one capsule adequate amounts of all the known essential vitamins in addition to 50,000 U. S. P. units of vitamin D.

Each Capsule Contains:

Vitamin D (Irradiated Ergosterol)	50,000 U.S.P. Units
Vitamin A (Fish-Liver Oil)	5,000 U.S.P. Units
Ascorbic Acid	75 mg.
Thiamine Hydrochloride	3 mg.
Riboflavin	2 mg.
Pyridoxine Hydrochloride	0.3 mg.
Calcium Pantothenate	1 mg.
Niacinamide	15 mg.
Mixed Natural Tocopherols	3.4 mg.

(Equivalent in biological activity to 3 mg. of Alpha Tocopherol)

J. B. ROERIG & COMPANY
536 Lake Shore Drive • Chicago 11, Illinois

DARTHRONOL *for the Arthritic*

a **ROERIG** *Preparation*



SO MUCH DEPENDS ON

EQUILIBRIUM

In managing cardiovascular disease, the restoration of "circulatory equilibrium",[2] and cardiac stimulation, usually constitute the chief therapeutic objectives. • Because of its *potent diuretic action,* which is "practically noninjurious... to normal kidney tissue",[1] Calpurate materially relieves the cardiac "load", and contributes to the prompt re-establishment of circulatory equilibrium. And by *direct myocardial stimulation,* Calpurate increases coronary output, and frequently achieves striking results in "relieving symptoms of congestive failure, angina and dyspnea."[4] Calpurate also exerts a *desirable dilating action* on coronary vessels. • Since Calpurate is almost insoluble in the stomach, yet readily absorbable in the intestine, it is remarkably free from gastric irritation—even on prolonged administration.[3,4]

FORMULA: Calcium theobromine—calcium gluconate in molecular proportions. • PACKAGED: as tablets (each containing 7½ gr. calcium theobromine—calcium gluconate) in bottles of 100, 500 and 1,000—or as powder in 1 oz. bottles. • ALSO AVAILABLE with ¼ gr. phenobarbital per tablet when sedation is desired.

THE MALTBIE CHEMICAL COMPANY • NEWARK, NEW JERSEY

CALPURATE

Relieves Symptoms—Yet Avoids G-I Upset

REFERENCES: 1. GOODMAN, L.: In The Therapeutics of Internal Diseases, edit. by G. Blumer, D. Appleton-Century Co., New York, Vol. 2, 1940. 2. HERRMANN, G. R.: Synopsis of Diseases of the Heart and Arteries, 3rd ed., C. V. Mosby Co., St. Louis, 1944. 3. WIPPERN, V. and GUNN, S. A.: Medical Times, 70:197, 1942. 4. ZISKIN, T.: Journal-Lancet, 57:292, 1937.



Styled for Individual Tastes

Neo-Synephrine for intranasal use is "styled" in three distinct forms too. All three provide the same real breathing comfort . . . prompt decongestion that endures for hours. Only the vehicles are different . . . isotonic saline, unflavored; Ringer's Solution, pleasantly aromatic; jelly in applicator tubes for convenience.

Neo-Synephrine

HYDROCHLORIDE

LAEVO-α-HYDROXY-β-METHYLAMINO-1-HYDROXY-ETHYLBENZENE HYDROCHLORIDE

For Nasal Decongestion

THERAPEUTIC APPRAISAL: Quick acting, long lasting . . . nasal decongestion without compensatory recongestion; relatively free from cardiac and central nervous system stimulation; consistently effective upon repeated use; no appreciable interference with ciliary activity; isotonic to avoid irritation.

INDICATED for symptomatic relief in common cold, sinusitis, and nasal manifestations of allergy.



ADMINISTRATION may be by dropper, spray or tampon, using the ¼% in saline or in Ringer's solution in most cases—the 1% in saline when a stronger solution is indicated. The ½% jelly in tubes is convenient for patients to carry.

SUPPLIED as ¼% and 1% in isotonic salt solution, and as ¼% in isotonic solution of three chlorides (Ringer's), bottles of 1 fl. oz.; ½% jelly in ⅜ oz. collapsible tubes with applicator.

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Division

DETROIT 31, MICHIGAN

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Trade-Mark Neo-Synephrine—Reg. U. S. Pat. Off.

EFFECTIVE IN BOTH *Acute and Chronic* EAR INFECTIONS



White's

OTOMIDE

combines, in a vehicle of unusually high hygroscopic glycerin, sulfanilamide, urea and chlorobutanol. This *stable* solution offers numerous advantages in topical treatment of either *acute or chronic* middle and external ear infections caused by sulfonamide-susceptible organisms.

SUMMARY OF ADVANTAGES

Antibacterial Potency—even in the presence of pus.

Stability—a *stable* sulfonamide-urea solution.

Wide Field—effective in *BOTH* acute *AND* chronic middle and external ear infections.

Well Tolerated—physiologic pH—virtually obviating local irritation.

Analgesia—effective chlorobutanol analgesia *without* impaired sulfonamide activity.

FORMULA

Sulfanilamide	5%
Carbamide (urea)	10%
Chlorobutanol	5%
Glycerin (high sp. gr.)	q. s.

•

White's Otomide is available in dropper bottles of one-half fluid ounce (15 cc.)—*on prescription only.*

PHARMACEUTICAL White LABORATORIES, INC. MANUFACTURERS



why ESTINYL *tablets in the menopause*

BECAUSE symptoms are controlled within a few days with only one 0.05 mg. ESTINYL (ethinyl estradiol) Tablet daily or every other day.

BECAUSE ESTINYL is well tolerated — Nausea and vomiting are uncommon, and patients experience a sense of well-being that helps smooth this transitional period.

BECAUSE ESTINYL is an economical preparation available to patients who require a potent estrogen derived from natural sources.

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Sedative-Antispasmodic



THREEFOLD ACTION Syntronal 'Roche' selectively inhibits parasympathetic terminations in smooth muscle. In addition, it has a direct relaxing effect on spastically contracted smooth muscle and it also relieves nervous tension and apprehension which are often important factors in spastic disorders. Syntronal will be found a valuable agent in spastic disorders of the gastrointestinal and urinary tracts, and in spastic dysmenorrhea. Syntronal is available in sugar-coated tablets, each containing 50 mg of Syntropan 'Roche' (phosphate of d,l-tropic acid ester of 3-diethylamino-2,2-dimethyl-1-propanol) and 15 mg of phenobarbital. Write to Department A-6 for a clinical sample of Syntronal. . . .

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SYNTRONAL

'Roche'





BRUCELLOSIS

(Undulant Fever)

A Menace often Undetected

"FIFTEEN years ago observed as a curiosity," Brucellosis is estimated as existing in "*ten to fifteen per cent of the American population*" . . . but unfortunately only "*one per cent or less* of infected cases reach detection and treatment."*

Whatever the source of infection—be it bovine, porcine, or other animal origin—Pitman-Moore Biological Laboratories offer a vaccine to meet your therapeutic requirements.

*Staub, R. R.: Brucellosis, An Unrecognized Menace, Northwest Med., 43:274-479 (Oct.), 1944.

Undulant Fever Vaccine
(Melitensis) (Bio. No. 60)
Brucella melitensis . . . 2000 million per cc.

Undulant Fever Vaccine
(Abortus and Suis) (Bio. No. 62)
Brucello abortus . . . 1000 million per cc.
Brucella suis . . . 1000 million per cc.

Both available in 6 cc. and 20 cc. vials.
Selection of type of vaccine depends upon the history of the case.
Full literature on request.

PITMAN-MOORE COMPANY

PHARMACEUTICAL AND BIOLOGICAL CHEMISTS

Division of Allied Laboratories, Inc., · Indianapolis 6, Indiana



INTESTINAL ABSORPTION
Long route through portal system to general circulation

ECONOMIC ANDROGENIC EFFECTS



PERLINGUAL ABSORPTION
Direct from sublingual vessels to systemic circulation



WITH SMALLER DOSES

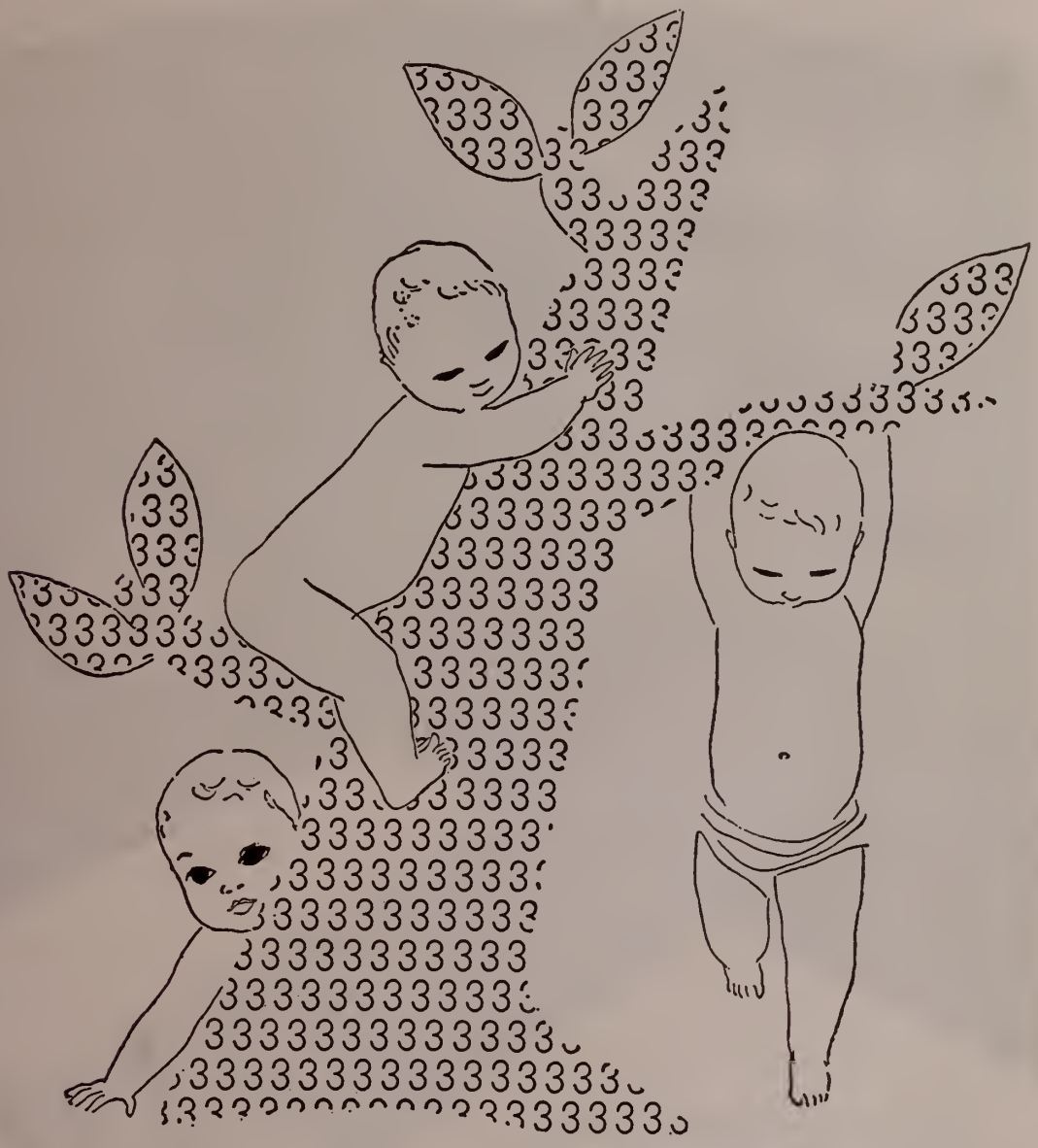
Metandren Linguets, especially designed for perlingual absorption, permit more complete utilization by side-tracking the liver where partial inactivation of methyltestosterone is known to take place. Dosage requirements are ½ to ⅔ those necessary to produce the same results when methyltestosterone is ingested.

METANDREN LINGUETS*

*Trade Mark Reg. U. S. Pat. Off. Ciba's trade name for wafers of methyltestosterone.

a Ciba Product

CIBA PHARMACEUTICAL PRODUCTS, INC. • Summit, New Jersey



babies grow on threes...

From infancy through late childhood, the average dose of Navitol with Viosterol is *only three drops daily.* This modern three-drop dose assures anti-rachitic protection for the normal child *throughout the active growth period.*

The maximum potencies of concentrated Oleovitamin A and D specified in U.S.P. XII —5000 U.S.P. units of vitamin A and 1000 U.S.P. units of vitamin D—are supplied in three drops. So palatable, Navitol can be placed right on the baby's tongue, if desired. So nearly odorless, it is an instant hit with mothers. And economical! The three-drop dose costs only half a cent a day!

Navitol
TRADEMARK
WITH VIOSTEROL

SQUIBB

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858



The active ingredient of Koromex Jelly is phenylmercuric acetate, whose remarkable contraceptive efficiency was affirmed in the illuminating report by Eastman and Scott (Human Fertility 9:33 June 1944). Their clinical and experimental data confirmed the earlier findings of Baker, Ranson and Tynen (Lancet 2:882 October 15, 1938). In addition to its excellent spermicidal efficacy, Koromex Jelly possesses to a high degree those other qualities which are physiologically and aesthetically so important to patients . . . For these reasons you can prescribe Koromex Jelly with *confidence.*

ACCEPTED AMERICAN MEDICAL ASSN.

Write for literature.

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Working at an accelerated pace, with their daily routine disrupted, more people than ever ignore the urge to evacuate, thereby increasing the incidence of constipation. 'AGAROL'* Emulsion provides deft and almost effortless supplementation to the finely balanced mechanism of normal evacuation. This smooth, palatable, free-flowing emulsion is geared to cooperate with natural physiological processes and to help reestablish a regular schedule of bowel movements...by retaining moisture in the stool, by supplying lubrication, and by mild stimulation of peristalsis. Bottles of 6, 10, and 16 fluidounces.

Trademark Reg. U.S. Pat. Off.

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Emulsion of Mineral Oil and an Agar-Gel with Phenolphthalein

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Wyeth
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Supplied in 8 fl. oz. and pint bottles

WYETH INCORPORATED • PHILADELPHIA 3 • PA.

COMPLICATIONS FROM PENICILLIN

The use of purer penicillin has markedly reduced such complications as phlebitis, pain at the site of injection, pyrexia, vascular and sympathetic disturbances, as well as muscular cramps.*



When you employ Bristol Penicillin in your practice you will find it:

1. Uniformly high in potency per milligram and
2. Markedly light in color.

Order Bristol Penicillin through your physician's or hospital supply house.

BRISTOL PENICILLIN

*Keys, J.E.L.: Penicillin in Ophthalmology, J.A.M.A. 126: 610 (Nov. 4) 1944.

BRISTOL
LABORATORIES
INCORPORATED

Formerly Cheplin Laboratories Inc.

SYRACUSE 1, NEW YORK



BY INJECTION

. . . subcutaneously or intramuscularly, ADRENALIN provides rapid symptomatic relief in asthmatic paroxysms; is useful in the prevention and treatment of other allergic reactions; localizes and prolongs the action of local anesthetics. Intravenously, it is used in shock and anesthesia accidents.

BY APPLICATION

. . . for its vasoconstrictor action in hemorrhage, ADRENALIN permits better visualization of the field, and aids in the diagnosis and treatment of certain conditions encountered in ear, nose and throat practice.

BY INSTILLATION

. . . into the nasal passage, ADRENALIN produces prompt decongestion; in the eye ADRENALIN decreases vascular congestion, and aids in the location of foreign bodies.

BY INHALATION

. . . orally, ADRENALIN relieves severe attacks of bronchial asthma by relaxing the bronchial muscles.

Its remarkable ability to stimulate the heart and increase cardiac output, raise the blood pressure, constrict the peripheral arterioles, dilate blood vessels of voluntary muscles, and relax bronchial muscles . . . makes ADRENALIN one of the most *versatile* and *useful* therapeutic agents at the command of the physician. Little wonder, then, that it's always kept close at hand in operating room, office, and medical bag.

To permit full use of its many therapeutic applications, there is a form of ADRENALIN (Epinephrine) to meet every medical need: Solutions of 1:100, 1:1000, 1:2600, 1:10,000; Suspension of 1:500 in oil; and Inhalant, Suppository, and Ointment.

ORIGINAL ADRENALIN

PARKE, DAVIS & COMPANY

DETROIT 32 • MICHIGAN



THE OSMOPAK* GLASS SPECULUM

The use of the OSMOPAK GLASS SPECULUM, as an improved technique in treatment of cervicitis, permits clearer observation, prevents injury to the vaginal wall. Made of pyrex glass suitable for sterilization, the speculum is placed directly against and circumscribing the cervix. By this means cautery can be more readily accomplished and medication more easily applied by tampon.

OSMOPAK, as a profound depleting agent, is ideally suited as medical treatment in simple cervicitis. The use of OSMOPAK, by tampon, immediately after cautery will definitely give a quicker and cleaner healing, will effect a better slough.[1] The product may be used in all trimesters of pregnancy without untoward effect.

The OSMOPAK GLASS SPECULUM is now available in small, medium and large sizes. OSMOPAK is available in 24 ounce jars, affords a water-miscible colloidal jel of Magnesium Sulfate (with Benzocaine and Brilliant Green). Write for descriptive literature.

1 Klein, H. L., J. Mo. State M A., April 1939
*T M Reg. U. S. Pat. Off.

IRWIN, NEISLER & COMPANY

DECATUR ILLINOIS

Irwin Neisler SINCE 1886

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Claims, words, clever advertising slogans do sell plenty of products. But obviously they do not change the product itself.

That PHILIP MORRIS are less irritating to the nose and throat is not merely a claim. It is the result of a manufacturing difference *proved** advantageous over and over again.

But why not make your *own* tests? Why not *try* PHILIP MORRIS on your patients who smoke, and *confirm* the effects for yourself.

* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

PHILIP MORRIS

PHILIP MORRIS & CO., LTD., INC.
119 FIFTH AVENUE, N. Y.

TO PHYSICIANS WHO SMOKE A PIPE:
We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.



and everything nice

That may be what little girls are made of. But irrespective of sex, the skeletal make-up of all infants, children, and young adolescents is dependent upon an adequate intake of vitamin D. Histologic studies at Johns Hopkins Hospital demonstrated rickets in 46.5% of a group of children between 2 and 14 years.

Super D* Concentrate provides high potency natural fish liver vitamins A and D—with vitamin D exclusively from cod livers—not only to protect against rickets but to assure adequate skeletal growth.

*Trademark, Reg. U. S. Pat. Off.

FINE PHARMACEUTICALS
SINCE 1886

Upjohn
KALAMAZOO 99 • MICHIGAN



"another three ounces— just right, young man"

...A familiar statement by physicians prescribing Biolac for infants deprived of human milk.

The protein level of Biolac assures an adequate supply for growth and health, with small, soft curds. The adjusted milk fat facilitates digestion and assimilation with greater freedom from "fat upsets"; and the ample lactose content assures a soft natural stool formation. The adequate proportions of lactose, iron, and vitamins A, B_1, B_2 and D eliminate the need for time-consuming calculations of extra formula ingredients. Indeed, Biolac (supplemented with vitamin C) provides *completely* for infant nutritional requirements throughout the bottle period.



Easily calculated... Quickly prepared. 1 fl. oz. Biolac to 1½ fl. oz. water per pound of body weight.

BORDEN PRESCRIPTION PRODUCTS DIVISION
350 MADISON AVENUE • NEW YORK, 17, N. Y.

Biolac is a liquid modified milk, prepared from whole and skim milk, with added lactose, and fortified with vitamin B_1, concentrate of vitamins A and D from cod liver oil, and iron. Evaporated, homogenized, and sterilized, vitamin C supplementation only is necessary. Biolac is available in 13 fl. oz. cans at all drug stores.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

Biolac—"BABY TALK" FOR A GOOD SQUARE MEAL

There is no *Universal Size*



THERE never has been a wedding ring that would correctly fit the finger of all women . . . and there is no universal size of occlusive diaphragm that will correctly conform to the many variations of the vaginal and cervical structures.

Competent clinical investigation has established that an occlusive diaphragm must be of individually correct size in order for the cervix to be properly protected against entrance of spermatozoa.

Because of the variance in the vaginal anatomy of individual patients the correct size can be determined only through measurement by a properly qualified physician.

To insure closer, more accurate fitting with greater comfort for your patients, specify "RAMSES"* Flexible Cushioned Diaphragm on your prescriptions.

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FLEXIBLE CUSHIONED DIAPHRAGMS



are made in gradations of 5 millimeters in sizes ranging from 50 to 95 millimeters inclusive . . . available through any recognized pharmacy.

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Gynecological Division

JULIUS SCHMID, INC.

Established 1883

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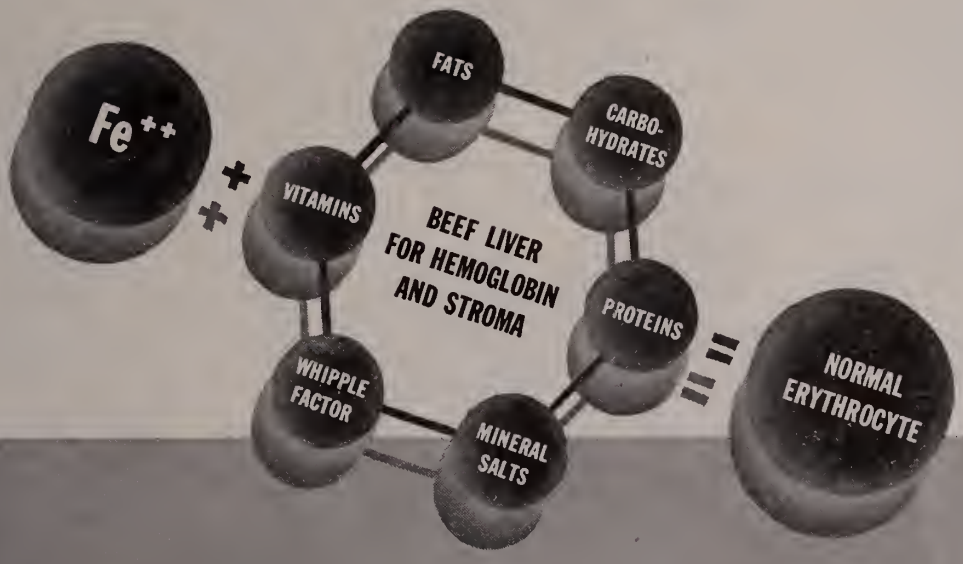
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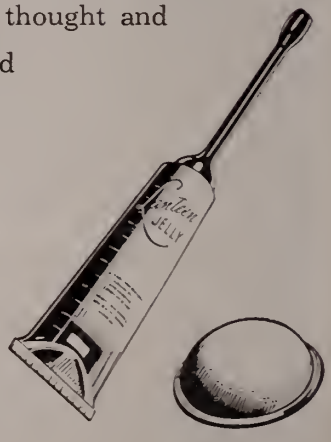
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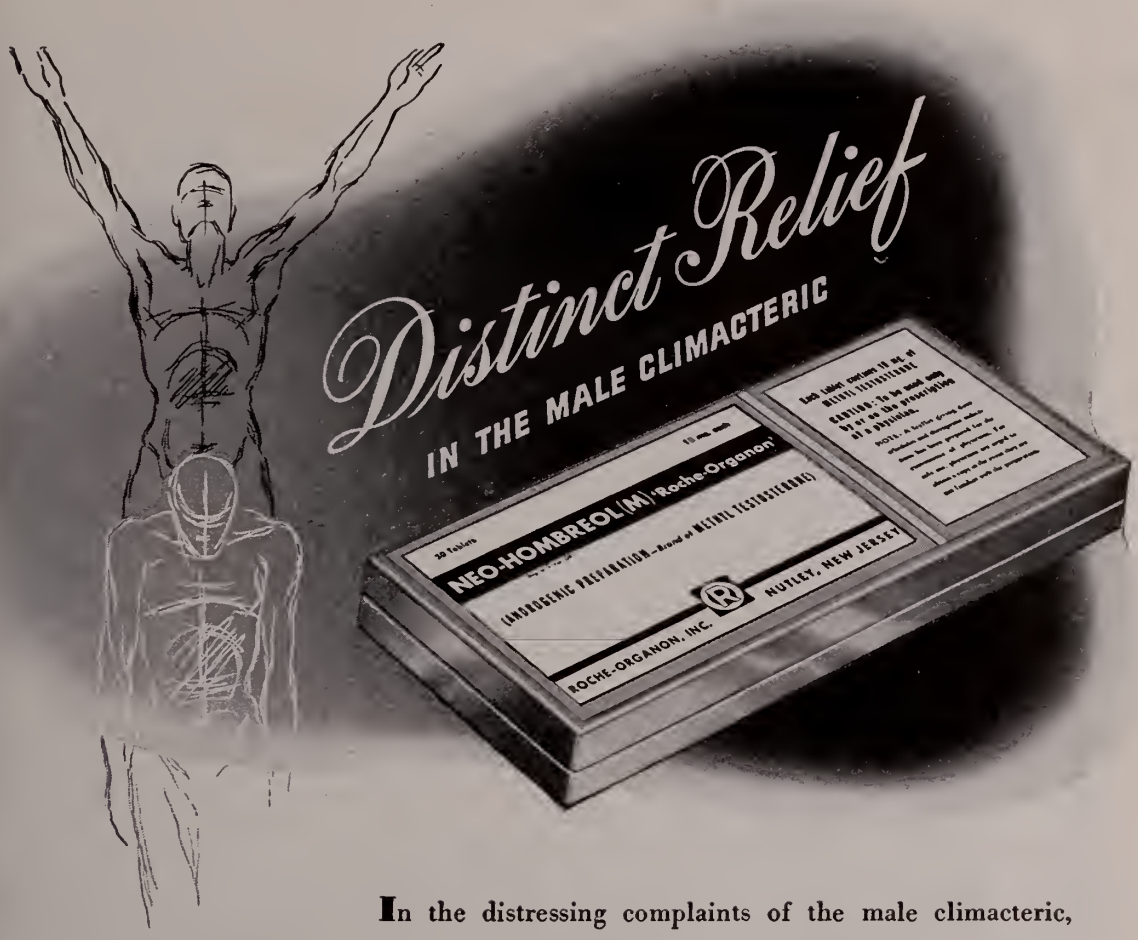
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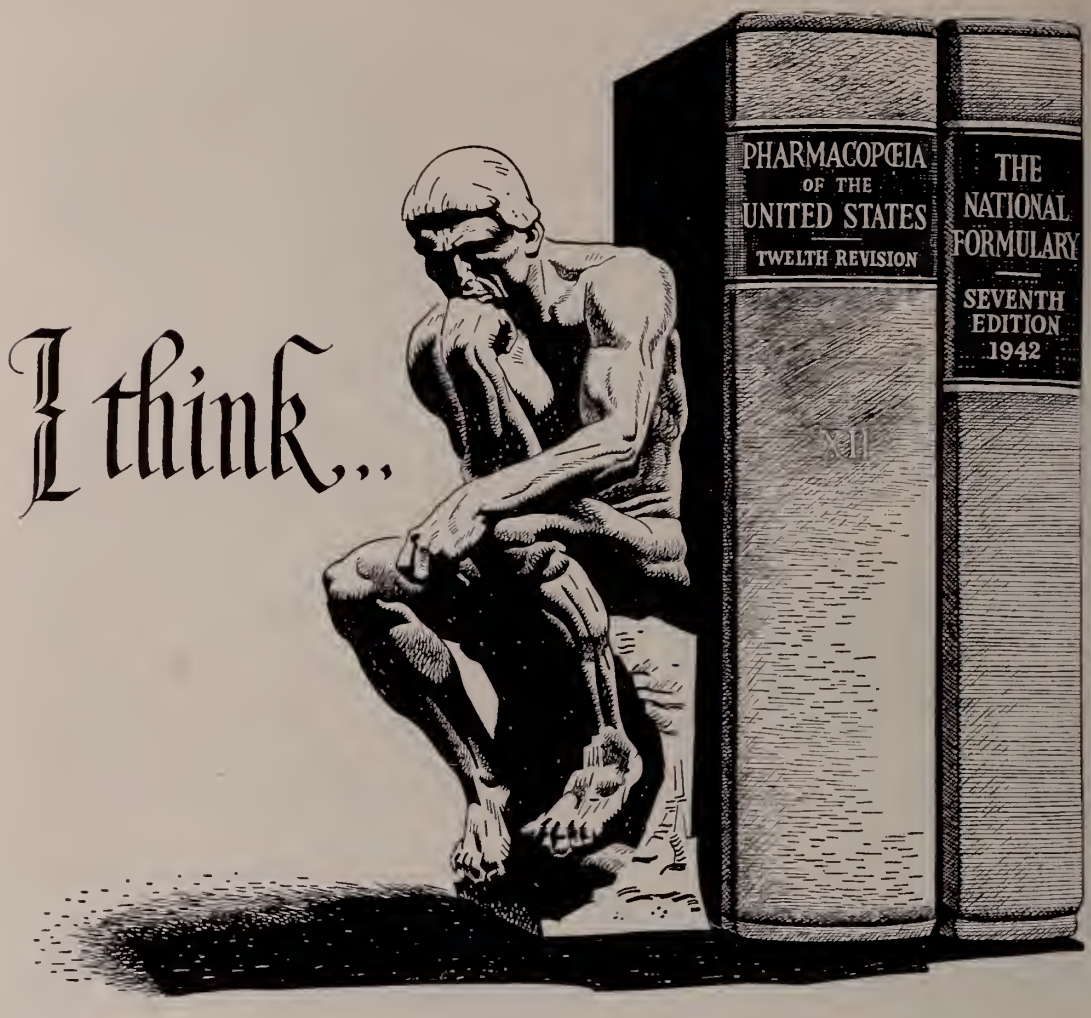
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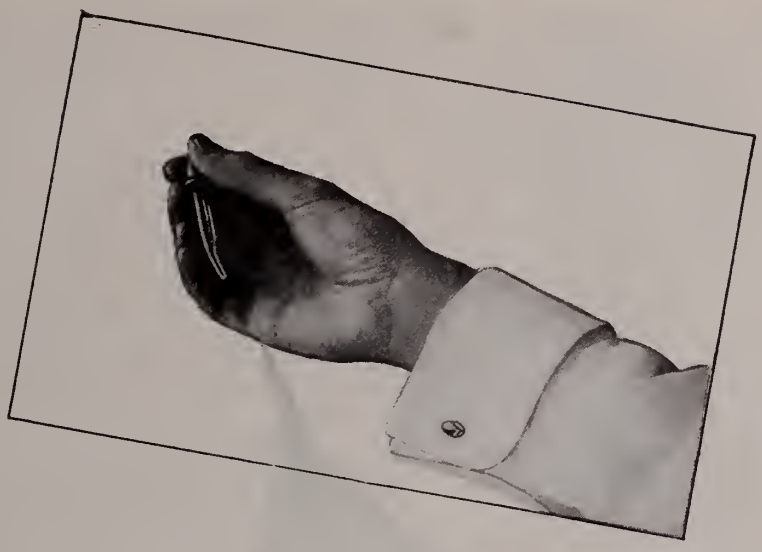
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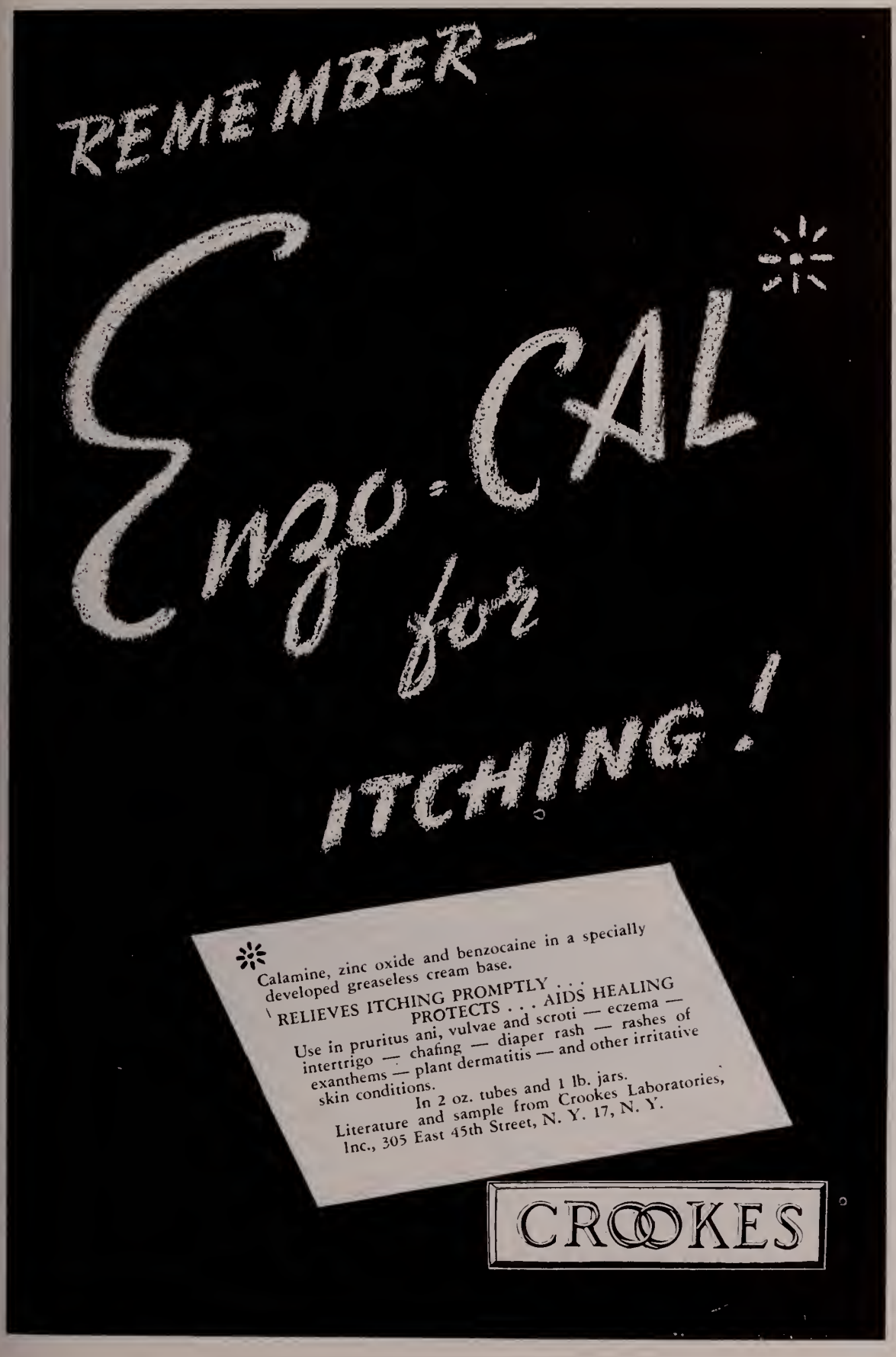
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SEPARATION OF MEDICAL OFFICERS FROM SERVICE

Within recent weeks the Procurement and Assignment Service for Physicians has received hundreds of letters, telegrams and phone calls from physicians desiring to be released at the earliest possible moment from the armed forces. In a number of communities petitions have been circulated and submitted with literally hundreds of signatures asking for the early return of their doctor. Previously a few physicians were released when it could be shown that there was an urgent need for them in the community where they formerly were in practice.

With the present point system many hundreds of physicians are now being released who have accumulated a sufficient number of points. It seems quite probable that this number will be increased quite materially during the last two months of this year as the Surgeon General of the Army has announced that approximately 13,000 are to be separated before the end of 1945.

Efforts are made constantly to get information as early as possible on the release of Illinois physicians. The secretaries of component county medical societies, as well as the county Procurement and Assignment Service Committees are being asked to submit information concerning the release and return of medical officers as soon as it is known locally. Every county society secretary and every Procurement and Assignment Service County chairman have received return postcards to list the names and addresses of every physician within the county who has already been released, and they are asked to keep a supply of cards on hand to report further releases as soon as they are effective.

In this way the Illinois State Medical Society will have this information, and it will be easier to anticipate community needs along the line of additional medical personnel in the files to aid returning men who desire to change their location, or those who have not been in practice previously.

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We have endeavored to maintain a list of those physicians who have been separated recently, although we realize that this list is not complete. Additions will be published in future issues of the Journal. We are publishing the name and address of those who have been released, and about whom we have been notified. Information concerning others who have not been reported will be greatly appreciated, and this data should be sent to the office of the secretary of the Illinois State Medical Society.

The list of Illinois physicians whose release from military service has been reported as of October 25, 1945, is as follows:

FROM DOWNSTATE

Adelman, Robert, Rock Falls.
Alen, Elmer S., Arcola
Anderson, Stanley Edward, Rockford
Ashworth, Adrian Lincoln, Anna

Barber, Harry Clay, Normal
Barthelme, Francis Lorraine, Effingham
Bartoli, Adolph, LaSalle
Baumann, Charles Hugo, Belleville
Berger, Raymond A, Galesburg
Blatchford, Frank W. Jr., Highland Park
Blocksom, Berget Henre Jr., Rockford
Blomberg, Thorsten Emil, Rockford
Bohan, John Edward, Toulon
Bolotoff, Bernard Edward, Rockford
Boswell, Clarence Henry, Rockford
Boyd, Douglas, Highland Park
Boyd, Olin Blackburn, East St. Louis
Brooks, Clyde M., Carbondale
Brown, Samuel, East Moline
Brown, Theodore Wallingford, Marissa
Buckley, Mortimer Joseph, Frankfort
Burgess, John Paul, Rock Island
Burkhart, George Hickman, Benton
Burley, Robert DeForrest, Beardstown
Bussey, Arthur David, Joliet

Carey, Charles Kennedy, Rushville
Chione, Alfred George, Danvers
Christenson, Albert William, Rockford
Cinelis, Adolph Richard, Marengo
Citron, Robert Raphael, Peoria
Cohen, Jacob, Granite City
Conway, Martin Eugene, Aledo
Cook, George Alexander, Silvis
Culhane, Thomas Henry Jr., Rockford

Davis, Irwin William, Belleville
Donovan, Ray Flowers, Watseka
Durra, Samuel Parnell, Rock Island

Eisenstein, Edward, Rockdale
Endres, Fred Carl, Peoria Heights

Farmer, David K., Mansfield
Fash, James Cane, Stronghurst
Feinerman, Albert Hyman, Macomb
Felts, William Froy, Carbondale
Fey, David William, Peoria
Flatley, Robert Edward, Moline
Fleischli, Frank Karl, Springfield
Fleischli, George Herman, Springfield
Frazier, Elijah S., Effingham

Gardner, Leon Philip, Joliet
Graland, John Courier, Elgin

Hanann, Carl Henry, Rockford
Hanson, Martin Franklin, Havana
Harmeyer, Mark Edward, Peoria
Hartford, William Scott, Champaign
Haskins, William Vincent, LaSalle
Heidgen, Martin F., Elmhurst
Helm, John Wesley, Gridley
Hughes, Mark Jacob, Grand Tower
Hungness, Norman Olaf, Sheldon
Hunsaker, Curtis Arthur, Marion

Illyes, Roscoe Orien, Lawrenceville
Isenhart, Lawrence Francis, Mount Caroll

James, Elmer David, Belvidere
Jenkins, David Meredith, Bloomington
Jensen, Russell Maben, Monmouth
Johnston, James Paul, East Moline

Kaiz, Seymour Pass, Waukegan
Kearney, Cletus Timothy, Gridley
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Koivun, Oscar Wilhart, Moline
Kunde, Emerson Charles, Woodstock

Leimbacher, Earl Smith, Joliet
Liebig, Gustav Adolph, Peoria
Liedermann, Albert, Sterling
Lofdahl, George Aleck, Joliet

Mack, J. Keller, Springfield
Mansion, George Nicholas, Pekin
McCall, Harold F., Dixon
McGinnis, William Schafly, Alton
McGrath, Philip Raphael, Peoria
McKinley, Hugh A., Highland Park
McNeely, G. B., Stanford
Merideth, John Andrews, Cobden
Messman, Lorrell Edward, Champaign
Mullen, Vincent Victor, Havana
Murfin, Maurice, Decatur

Neff, Emery Bowers, Moline
Nolan, Charles Joseph Jr., East St. Louis
Norris, Millard Fillmore Jr., Pawnee

O'Casek, Miles Frank, Elmhurst
Oliver, Wesley Bair, Belvidere
O'Neill, Paul Joseph, Alton
Oxman, Emanuel M., Kankakee

Parker, Elliott Francis, Moline
Parker, Meyer Herbert, Louisville
Patterson, Roy Lee, Canton
Pearson, Emmett Forrest, Springfield
Percy, Irving E., Roxana
Powell, John Rodger, Champaign
Powell, Paul Wayne, East Moline

Raiford, Theodore Sidney, Decatur
Ranker, Clarence Andrew, Springfield
Reinhardt, Charles Otto, Mascoutah
Robinson, Leon Edward, Aledo
Rockey, Lawrence Frank, Freeport
Rockey, Victor Vernon, Freeport
Rogers, James Creighton T., Urbana
Rokita, Adam Walter, Quincy
Rosenbaum, William Harry, Deerfield
Rossman, Edward John, Aurora
Rutherford, Robert Horace, Carlinville
Ryder, Bruce Ivan, Henry

Sandberg, Ivan Magnus, Princeton
Sawyer, Preston Walker, Kankakee
Scanlon, William, LaSalle
Schach, Arthur Carl, Rockford
Schiller, Herbert A., Kankakee
Scopelight, Joseph Aloysius, Madison
Shamel, John Hayden, Springfield
Sherrod, Vincent Alan, Robinson
Shriner, Walter, Springfield
Siegert, Rudolph Bernhardt, Pana
Sirles, Wayne Pulley, Herrin
Slatin, Louis, Decatur
Sokolowski, Felix Walter, Alton
Stafford, Wilfred Farber, Mattoon
Stanul, Peter Joseph, North Chicago
Steinberg, Richard Mitten, Fairbury
Stephenson, George Willoughby, Bloomington
Stolpestad, Clifford Theodore, DeKalb
Summers, Thomas Fern, Olney

Talbert, Wilmer M., Decatur
Tavenner, John Lyle, Dixon
Teasley, Benager Columbus Jr., Robinson
Telford, Elbridge Wright, DeKalb
Thompson, Neill Archie, Eldorado
Tomkens, Samuel William, Hampshire

Uthoff, Carl Joseph, Elmhurst
Utter, Henry Abraham, Anna

Wadsworth, Harold Vivian, Joliet
Wagenseller, Samuel Miller, Decatur
Walker, William Dallas, Ashley
Wathier, Lawrence Nicholas, Atkinson
Weston, Charles Leland, Macomb
Wiesman, Irvin, Granite City
Wise, Albert Walter, Rock Island
Wisshack, Erich Eugene, Adair
Wolfe, Albyn Garrett, Jacksonville
Woll, Maurice, Alton
Wood, George Carlyle, Effingham
Wood, Oliver Marshall, Ipava

Young, Leslie Winters, Fairfield

FROM COOK COUNTY

Allegretti, Joseph E., 2445 North Sawyer Ave.,

Baratz, J. Joseph, 6549 North Artesian Ave.
Barryte, Lucien E., Jr., 2104 Belmont Ave.,
Bay, Anthony, 628 Wrightwood Ave.,
Besick, Anna C., 6805 Cermak Rd., Berwyn
Bilek, George J., 2650 South Homan Ave.,
Blatchford, Frank W., Jr., 723 Elm St., Winnetka
Boland, Joseph J., 1110 North Austin Blvd., Oak Park
Bornemeier, Walter C., 55 E. Washington St.,
Bowler, Vincent B., 712 North Austin Blvd., Oak Pk.
Bowser, Albert W, 1853 S. 60th St., Cicero, Ill.
Boykoff, Max P., 2022 Arthur Ave.
Brewer, John I., 2222 E. 70th Pl.
Buckley, Mortimer J., White St., Frankfort, Ill.
Burket, Walter C., 2750 Ridge Ave., Evanston

Chardkoff, M. Austin, 1001 Leland Ave.
Colletti, Michael J., 127 S. Central Park
Conley, Arthur H., 559 Franklin Ave., River Forest
Cook, Franklin, 2747 Hurd Ave., Evanston
Corbus, Budd Clarke, Jr., 636 Church St., Evanston
Crain, Ransome Carter, 30 North Michigan Ave.

Dashiel, Grayson F., 408 Briar Place
Davis, Loyal, 54 East Erie St.
DePinto, Dominic A, 2400 West Van Buren St.
DeTrana, Frank A., 4815 West Nelson St.
D'Iorio, Philip J., 3908 Cottage Grove Ave.
Duggan, Daniel J., 515 North East Ave., Oak Park
Dvorak, Emanuel R., 2510 Christiana Ave.

Ebert, Benjamin L., 540 Briar Place
Effron, David V., 2208 East 68th St.
Egel, Paul M., 5018 North Kimball Ave.
Ellwood, Walter W., 5125 South Ellis Ave.
Erxleben, Walter O., 5848 N. W. Circle

Farinacci, Maurice G., 5519 South Talman
Feldman, Morris, 4013 Milwaukee Ave.
Forkosh, Sydney R., 6820 Raven St.
Francona, Anthony, 1636 North Nordica.
Franklin, Charles E., 7202 Oak St., River Forest
Frisch, Isaac J., 25 E. Washington St.

Galloway, Charles E., 636 Church St., Evanston
Goldstein, Morris, 6879 Wildwood Ave.
Goodhart, J. A., 6557 South Francisco
Green, Raymond, 5105 Drexel Blvd.
Grill, Frank T., 1858 Cermak Road
Grombacher, Curt S., 1228 Argyle St.
Guttman, Joseph R., 185 North Wabash Ave.

Hawkins, Kyle C., 5200 West Chicago Ave.
Hoeppner, Walter F., 1912 West 103rd St.
Hoffstadt, John P., 6355 Broadway
Hootnick, Harry L., 5524 N. Mason St.
Hootnick, Jacques I., 8015 Kingston Ave.
Horwitz, Bernard L., 2636 Farwell Ave.
Horwitz, Herman L., 11106 South Michigan Ave.
Howser, John W., 304 N. Lombard Ave., Oak Park
Hubrich, Leon R., 5735 Roscoe St.

Ignoffo, Matthew F., 1628 Gregory Ave.

Jablonowski, Alexander, 2922 East 79th St.
Jackson, Bruce E., 1745 West Steuben St.
Jakopick, William Francis, 10344 S. Leavitt St.
Janda, Charles L., 3534 West 26th St.
Johnson, Carl A., 5208 South Greenwood Ave.
Juliano, Aniello A., 7827 Crandon Ave.

Karabin, Andrew L., 11117 Emerald Ave.
Kaufman, Saul D., 1608 Milwaukee Ave.
Keane, John W., 1211 N. Linden Ave., Oak Park
Kearney, Richard D., 3400 West 64th St.
Keren, Meyer J., 4800 Milwaukee Ave.,
Kessler, Charles T., 4325 Elston Ave.
Kittilsen, Lester H., Park Ridge, Ill.
Klocker, Karl J., 1833 N. Newland Ave.
Koll, Irvin S., 25 E. Washington St.
Krol, Edward J., 6952 South Talman Ave.

Latimer, Earl O., 7549 Crandon Ave.
Latz, Leo J., 2958 West Hollywood.
Lavieri, Frank J., 5000 West Madison St.
Lazar, A. M., 30 North Michigan Ave.
Levenson, Joseph M., 6254 South Ashland Ave.
Lodato, Victor, 1601 Halsted St., Chicago Heights.
Love, A. I., 3347 Wilson Ave.

McDaniel, Paul, 2608 Lakeview Ave.
McLean, Dan R., 4359 West Division St.
Macaluso, Leonard A., 3620 North Magnolia Ave.
MacDonald, Hugh, 912 Glenwood Lane, Glenview.
Madden, Earl E., 7350 South Phillips.
Magnus, A. B., Central Rd., Arlington Heights.
Malanca, Francis X., 1841 S. 51st Ct., Cicero.
Mark, Samuel J., 5834 North Bernard Ave.
Markin, Leonard E., 25 E. Washington St.
Mason, Frank N., 1246 West Jarvis Ave.
Meyer, Herschel, 41 S. Central Park Ave.
Miller, Louis J., 2021 North Whipple St.
Modzikowski, Thaddeus A., 8019 Kingston Ave.

Neiman, Aaron, 4010 West Madison St.
Nigro, Salvator, 3655 West Chicago Ave.
Norris, Millard F., Pawnee, Illinois.

Pachynski, Bernard L., 7350 Oglesby Ave.
Patka, Joseph A., 4725 South Avers Ave.
Perritt, Richard A., 221 E. Walton Pl.
Petrone, Joseph A., 1958 Grand Ave.
Pitzaferro, John J., 323 S. Ashland Ave.
Plucinski, Stanley J., 6110 S. 75th Ave., Argo.
Przygocki, S. F., 4868 Warner Ave.
Puntenney, Irving, 720 North Michigan Ave.

Rampona, Louis E., 6 North Michigan Ave.
Ricci, Henry N., 4506 West End Ave.
Ricewasser, Henry, 6156 North Winthrop Ave.
Robinson, Harry Marchmont, 8333 Indiana Ave.
Romanski, Arthur F., 2332 S. Highland Ave., Berwyn
Rosanova, Albert R., 1241 North Keeler Ave.
Rosen, Isaac, 5209 Ingleside Ave.
Rosenberg, Harry, 6356 North Broadway.
Rottman, Morris M., 4819 North Drake Ave.

Saletta, Charles A., 2438 North Neva Ave.
Schwartz, Max J., 6354 Broadway.
Shafton, Arthur L., 639 Deming Place.
Shalla, Leon S., 2922 North Luna Ave.
Shapiro, Bernard, 4760 North Bernard St.
Shevin, Selig A., 6700 Stony Island Ave.
Shufflebarger, Forrest G., 225 S. Sheridan Rd., Winnetka.
Simonelli, Mario, 2516 N. Harlem Ave., Elmwood Pk.
Smialek, John M., 2200 Walton Ave.
Sneider, Milton J., 2756 North Kimball Ave.
Spackman, Ross H., (Address Unknown)
Spector, Israel H., 5419 Greenwood Ave.
Steinberg, Frederick B., 29 East Ohio St.
Steinhoff, Carl F., 6134 North Washtenaw Ave.
Stenn, Arthur, 1811 West 47th St.
Straus, Francis H., 1312 Astor St.
Strich, Arthur J., 3350 West Diversey Ave.
Stupnicki, Joseph, 3103 South Morgan St.
Sullivan, Donald G., 9807 South Leavitt St.
Sullivan, Francis J., 804 Waukengan Rd., Glenview.

Tauber, Sydney Wm., 3958 West Chicago Ave.
Thomsen, Philip G., Dolton, Illinois.
Trapp, Anthony N., 1450 Winona Ave.,
Tsoulos, George D., 6534 Stony Island Ave.
Turek, M. H., 4010 West Madison St.

Urkov, Joseph C., 55 E. Washington St.
Uthoff, Carl J., R. F. D., Lowell, Oregon.

Van Dellen, Theodore R., 303 E. Chicago Ave.

Waters, Carl F., 5711 West Chicago Ave.
Weiskopf, Henry Sol, 1610 West 5th Ave, Gary, Ind.
Wicks, Mark, 1019 Bryn Mawr.
Wieneke, Carter H., 1356 Greenleaf Ave.

Zanette, Alfred A., 4959 West Chicago Ave.

VIEWS OF ILLINOIS LEGISLATORS ON THE WAGNER-MURRAY-DINGELL BILLS

In order that we might ascertain the views of many members of Congress from Illinois, the following letter was sent to the Senators and Representatives from this state under date of October 6, 1945.

"The Medical Profession of Illinois, is, as you know, overwhelmingly opposed to the program of state medicine proposed by the compulsory 'health insurance' features of the Wagner-Murray-Dingell Bills. They see in that program the groundwork for a system of socialized or government controlled medicine unparalleled in history.

"The profession of Illinois is greatly inter-

ested and much concerned as to the attitude of the United States Senators and Representatives from Illinois upon this vital issue. So that the membership of this society may be more fully and currently informed as to the views of their members of the Congress upon this subject, we are inviting each Senator and Representative to give us an expression of opinion for publication in the November 1945 issue of the Illinois Medical Journal. The printer's 'deadline' for that issue is October 24, 1945.

"Whether American Medicine shall or shall not be socialized is a question of transcendent importance, not only to the medical profession, but to the rank and file of the American People. An expression of your views in the matter would be greatly appreciated."

Realizing that members of Congress have been unusually busy since their vacation recess, and that only a short amount of time was permitted them to get their reply back to the editor, only 12 replies were received by October 24, but we will most likely hear from many more in the coming weeks.

Senator Lucas stated "with respect to the Wagner-Murray-Dingell Bills, candidly I do not know all the details contained in these bills. I do not know what amendments will be offered, if and when the legislation reaches the floor of the Senate. It is impossible for any one Senator to consistently advise his constituents what his views are upon complicated bills until a particular measure is perfected through amendments. I have always been opposed to socialized medicine. I see no reason for changing my viewpoint at this time. It must be remembered, however, that the Wagner-Murray-Dingell Bills, as I know them, contain more than that one point."

Rep. Rolla C. McMillen of the 19th District stated: "Your letter of October 6th regarding the Wagner-Murray-Dingell Bills has been received, and I was glad to have the opinion of your profession on this legislation. I am inalterably opposed to socialized or government controlled medicine and you may be assured that I will vote against such a measure if it reaches the Floor of the House."

Rep. Emily Taft Douglas, Member at Large, replied: "You may rest assured that I am studying the bill in question very carefully and that I am seeking information from all competent sources. I am collecting the opinions of the various medical societies on the bill and I am giving careful weight to them."

Rep. Everett M. Dirksen of the 16th District wrote: "Let me express my thanks and appreciation for your note of October 6 in which you indicate the opposition of the profession to the health features of the pending Wagner-Murray-Dingell Bill. I presume you have been informed that the bill is pending before the Finance Committee of the Senate Ways and Means Committee of the House and has as yet received no committee action. Be assured that I shall be on the alert and give it sustained and careful attention."

Rep. Robert B. Chiperfield of the 15th District stated: "This will acknowledge receipt of your letter concerning the Wagner-Murray-Dingell Bills. I have publicly stated I am opposed to the program of state medicine as proposed in this pending legislation."

Rep. Jessie Sumner of the 18th District wrote: "Thank you for your letter. I am opposed to the Wagner-Murray-Dingell Bill."

Rep. Melvin Price of the 22nd District stated: "I have your letter of October 6th on behalf of the Illinois Medical Journal containing your expression of views regarding the Wagner-Murray-Dingell Bill, S. R. 1060. Thank you very much for your interest in writing to me in this matter. Your opinions are deeply appreciated. May I extend to you the facilities of this office at any time they may be helpful."

Rep. L. C. Arends of the 17th District stated: "I will immediately answer your letter of October 6th, wherein you ask what my views are concerning the Wagner-Murray-Dingell Bill, S. R. 1060 and H. R. 329, which bills if passed would create the socialization of medicine. For your information, I am opposed to socialized medicine and have so advised my local medical organizations in the 17th Congressional District."

Rep. Ralph E. Church of the 10th District wrote: "I am in receipt of your letter of October 6th with reference to the opposition of the medical profession of Illinois to the so-called Wagner-Murray-Dingell Bills. I have always opposed the regimentation of any profession and that includes the medical profession especially."

Rep. Anton J. Johnson, of the 14th District wrote: "I have your letter of October 6th rela-

tive to the Wagner-Murray-Dingell Bill. I concur with your views that if this program is put into effect it will be more or less a system of socialized or government controlled medicine unparalleled in history. You may be assured I shall oppose any such program. Thanking you for your interest in this matter, I am"

Rep. N. M. Mason of the 12th District wrote: "This will acknowledge receipt of your letter of October 6 relative to the Wagner-Murray-Dingell Bills. I am opposed to the socialization of medicine and hospital care, and therefore expect to oppose the passage of these measures."

Rep. Charles W. Vursell of the 23rd District wrote: "I am against the bill and have been against all bills tending toward the socializing of medicine. In fact, if you will look up my record you will find that I might well be classed as a 'Tory', or an 'Economic Royalist'. However, I am neither. I am for sound Government, believe we have done pretty well up to date, am against a one world philosophy, and don't want to suddenly remake America."

We realize the difficulty of our Legislators giving a definite statement relative to the Wagner-Murray-Dingell Bill with its approximately 185 pages, and covering so many subjects, one of which is the medical care program, this being the one which is of paramount interest to the medical profession. We also realize that in opposing such a measure, we should be prepared to offer a substitute plan which would give adequate medical care to those in low income groups, preferably a plan to give this care on a prepayment basis.

It is hoped that a prepayment medical care plan will be in operation in this state in the near future, and for many months a special committee has been making intensive investigations of all plans now in operation, and through frequent reports of progress to the Council, some definite decisions have already been made.

We are grateful to those Legislators who have responded to our letter, realizing that never in the history of this country has our Federal Congress had so many important decisions to make, and so much business to transact. Comments on replies to be received later will be published in the Illinois Medical Journal at an early date.

THE DEVELOPMENT OF ROENTGENOLOGY DURING FIFTY YEARS

Although considered one of the youngest of specialties in Medicine, Roentgenology is actually fifty years old, for it was in 1895 that William Conrad Roentgen discovered the x-ray. This branch of Medical Science has indeed gone a long way from the crude, static machine to the ultra modern types seen everywhere today. It is most fitting that the period from November 5 to 10 has been selected to give proper recognition to this 50th anniversary and to familiarize the public with the use of x-ray as a diagnostic and therapeutic instrument.

Many physicians will recall that the early use of x-ray was restricted principally to the recognition of foreign bodies in human tissue and to recognize the presence of fractures. Today in both diagnostic and therapeutic considerations, every part of the human body is indeed accessible to its many services.

The proper correlation of roentgenological and clinical findings has made x-ray indispensible in the daily routine examinations. Chest roentgenograms have materially simplified the early diagnosis of tuberculosis and other chest diseases; visualization of the gastro-intestinal tract, genito-urinary tract, biliary tract, and all other parts of the human body have added materially in accumulating clinical data.

Recent developments in bone surgery and especially in connection with osteomyelitis and bone tumors were largely brought about through the use of modern x-ray equipment. More recently it has been used extensively in hematology and especially in connection with the treatment of chronic leukemia, where many gratifying results have been obtained.

In considering this fiftieth anniversary of the discovery of x-ray by Roentgen, it is most fitting indeed, that tribute be paid to those thousands of men in this branch of medical science who have developed the field and at a great risk, for it has not been within the entire fifty year period that modern safeguards have removed the dangers to the investigators and operators of x-ray equipment.

Physicians everywhere should cooperate in the celebration of this anniversary and during the period of November 5 to 10, utilize every opportunity to tell friends of the value of this important branch in modern medical work.

Medical Economics

The Medical Economics Committee — Chauncey C. Maher, Chmn., 6 North Michigan Avenue, Chicago, Edwin S. Hamilton, V. Thomas Austin, Emmet B. Bay, Jay McDonald Milligan, Jacob M. Mora, George Halperin, Marie Wessels, Thomas C. Browning, Roland R. Cross, Milton E. Bitter, Edwin F. Hirsch, Ford Hick, Lt. Col. MC, William J. Bryan, John R. Vonachen.

PROBLEM IN THE PRESENT DAY PRACTICE IN OBSTETRICS IN THE STATE OF ILLINOIS

Milton E. Bitter, M.D.

In October 1942 the Emergency Maternity and Infant Care Program came into active being in this State. When it was originally introduced, and it is a part of the record, the Chief and the Associate Chief of the Children's Bureau gave repeated assurances that the EMIC Program was distinctly a war emergency measure which would cease to function six months after the close of hostilities.

The members of the Maternal Welfare Committee of the State of Illinois and also the members of the Advisory Committee to the State Department of Maternal and Child Welfare agreed to accept this Program in good faith and assume it as an educational as well as a patriotic duty. Those who hesitated to believe all the promises made at that time need make no apologies for their skepticism for we have ample proof today that it was only another "camel's nose under the tent" program, as evidenced recently by the introduction of Senate Bill 1318.

The Maternal Welfare Committee of the State of Illinois had long before set up and had established an educational program to insure better obstetrics for the entire State and to assure the men in the Armed Forces that their wives and infants would receive better care.

Adoption of the EMIC Program by the medical men of this State entailed a tremendous amount of clerical work, besides much delay in collecting fees — and then having the fees, in many instances, slashed due to restrictions and misunderstandings.

I believe the medical men of the State have done an excellent job of cooperating, but now that hostilities have ceased we are being confronted with an honest-to-goodness super-duper plan proposed in the Maternal and Child Welfare Act of 1945. In my opinion, the proposed legislation, by the powers that be, is hastening the regimentation of the United States and is making permanent, by congressional action, the EMIC Program. In looking over this Act you find that the State Departments of Public Health are to be the subsidiary accomplices in the carrying out of these concepts.

The Advisory Committee to the Department of Maternal and Child Welfare, of which I am a member, has about one per cent recognition in this matter. It is interesting to note that the Associate Chief of the Children's Bureau is Dr. Martha Eliot. It is interesting to note that this Senate Bill 1318 was referred to the Senate Committee on Education and Labor, of which Senator Murray of Montana is Chairman. It is also interesting to note that the recommendations in support of this Bill were formulated mostly by representatives of labor interest and social workers, and that only two of the nine division directors are Doctors.

Evidence of resentment by the doctors toward the EMIC Program is widespread, yet few of the sponsors of this Program appreciate the fact that such a condition exists. Others, holding this resentment, don't take an active part in curbing its progress.

★ BUY VICTORY BONDS ★

State Department of Public Health

THE YEAR'S ADVANCEMENT IN PUBLIC HEALTH

ROLAND R. CROSS, M.D., DIRECTOR

The enactment of a good deal of important legislation; considerable progress in the development of county health departments and improvement in the infant and maternal death rates characterized the year ending June 30, 1945 as one of the most eventful in the public health history in Illinois. Although it was the third year of active warfare for the Nation, health conditions generally in the State were favorable both as to the prevalence of communicable diseases and mortality experience.

The new developments are regarded as particularly significant on the grounds that they reflect the cumulative effect of popular interest in public health service which has been growing rapidly in recent years. A sizeable increase in the appropriations to the Department, for example, and the passage of laws that are described in some detail below, took place without important controversy or challenge in the General Asembly. Not a few members of the General Assembly, moreover, expressed favorable interest in larger appropriations than called for in the budget of the Department of Public Health, especially as to the control of tuberculosis and cancer. These observations imply strong popular favor inasmuch as the legislators are sensitive to public opinion.

The movements that brought into existence the county health departments where they have been established under the provisions of the new law, and where the proposition of creating such departments is pending, were initiated locally for the most part. This implies fundamental public interest in organized community effort for health protection and also confidence on the part of the people in the county health department proposition, as recommended by the State Department of Pubilc Health.

LEGISLATION

An appropriation of $2,162,000 was made for the construction in Springfield of an office building to house the Department of Public Health. Approximately $77,000 had been obtained from the Federal government to be applied toward the costs of architect's plans and specifications for this project. At the end of the year, the plans were well advanced toward completion and the site of the building had been selected. Acquisition of the property remained to be accomplished before all would be ready to start construction work.

An appropriation of $3,850,000 for the construction of five tuberculosis sanitariums and $150,000 for the acquisition of sites therefor was made. In the appropriation Act it was specified that four of the sanitariums were to be located down-state and one in Cook County. Plans call for allocating the money equally between Cook County and the remainder of the State so that the number of beds in the Cook County institution would be equal to the combined total in the four down-state ones.

The regular appropriation to the Department of Public Health was $4,121,088. The principal new feature is an item of $250,000 for grants-in-aid to county health departments. The total appropriation is $880,105 higher than two years ago, $490,568, representing money needed to comply with new and higher salary ranges established by the General Assembly.

A new law requires that nursing homes be licensed by the Department of Public Health on the basis of minimum standards as to sanitation, hygienic features, diet and personnel. This legislation came about as the result of popular interest that expressed itself in an organized effort favoring a licensing law.

The law in relation to hotels and inns was amended so as to require the Department of Public Health to establish and enforce minimum standards as to sanitary facilities. The definitation of hotels was changed so as to include all places that maintain rooms for hire to transient lodgers. This legislation was initiated by the railroad brotherhoods with the end in view of improving sanitary conditions in the lodging houses and hotels at railroad terminals maintained especially to accommodate railroad employees.

The laws relating to the sanitation of pasteurized and grade A milk supplies were rewritten, simplified and so worded as to raise the minimum standards of sanitation.

A law was passed that permits cities of less than 100,000 population to levy a special tax to cover the operating expenses of sewage treatment plants. This specific method of financing operation should encourage the construction of such plants in the 80 odd municipalities where they are now needed to abate the pollution of streams.

Several other new laws were passed and other laws amended that affected the Department of Public Health but were of less importance than those referred to above.

COUNTY HEALTH DEPARTMENTS

During the year a popular vote was taken on the proposition of establishing a county health department and levying a tax therefor in each of five counties. The result was favorable by a substantial margin in Adams, DuPage, McLean and Montgomery counties. The proposition failed curiously to carry in St. Clair. Although the total vote in the county was heavily favorable, the vote outside the East-Side Public Health District, (which includes East St. Louis) was unfavorable and caused the proposal to fail inasmuch as the law requires a favorable vote both within and outside a Public Health District when one exists in a county.

Interest in establishing health departments is active in a number of other counties. The outlook for rather rapid developments along this line is promising. It is anticipated that efforts will be made to place the proposition on the ballot in twenty or more counties during the biennium.

HEALTH CONDITIONS

The infant death rate, believed by competent observers to be one of the most sensitive and accurate indexes to prevailing health conditions, was lower in the calendar year of 1944 than in any previous year of record in Illinois. The rate was 32.4 per 1000 live births reported against a previous low of 33.0, the figure for 1942.

The maternal death rate, likewise considered a sensitive index, was also lower than in any previous year of record, 1.8 deaths per 1000 live births reported against the previous low of 1.9, the 1942 figure.

It seems probable that the medical and hospital care provided at Government expense for the pregnant wives and infant children of enlisted men in the armed forces had a favorable influence over the health and death rates among child-bearing mothers and babies. Care was provided for 21,739 mothers and for 2,243 babies during the calendar year of 1944 through the administration of the Emergency Maternity and Infant Care program. While this number is only about one-sixth of all the births that took place in the State in 1944, the care given was the best available and probably raised significantly the average standard of care received by all.

The general death rate of 11.42 per 1000 estimated population was somewhat higher than the experience in some previous years. Two factors may be partly responsible for the higher rate. Large numbers of young men were withdrawn from the civilian population into the armed forces, leaving behind the older people among whom a higher mortality prevails. The estimate of the population may not be as accurate as during normal peace time. If it was low; the rate is proportionately higher than it should be. In any event the rate is by no means excessive and indicates generally favorable conditions.

There were no unusually wide-spread or devastating epidemic outbreaks of communicable diseases.

PERSONNEL

The shortage of personnel was still acute at the end of the year, especially as to medical officers and sanitary engineers. Through con-

tinuous and diligent efforts at recruitment, on the other hand, the strength of the nurses has been raised somewhat above the pre-war level. Gains have been made also as to public health educators. Special training at various schools of public health has been provided on an all-expense scholarship basis for a considerable number of nurses and for health educator trainees. The Department's own training course for laboratory specialists was continued through the year. By these methods the over-all strength of the Department's personnel has been maintained throughout the war years at a considerably higher level than seemed likely in the early days of the war.

SERVICES

The program and activities of the Department remained on a war-time basis. The several Defense Zone Health Departments were maintained at the maximum strength permitted by the resources of the Department. These services were concentrated in areas of exceptional military importance and appear to have fulfilled to a high degree their purpose of protecting the health of large populations engaged in work essential to the war effort. It is expected that when the war ends the people concerned will have been sufficiently impressed by the operation of the Defense Zone Health Departments and the beneficial results thereof that many if not all of these departments will be retained on a permanent basis by appropriate action as local health departments.

Looking forward to the post-war period, plans for expansion and intensification of services in conformity with recognized and anticipated needs and resources have been projected. These plans revolve around the development of strong, adequate local health departments and particularly county health departments. It is believed that only through the efficient operation of good local health departments can the maximum potential benefits from public health service be enjoyed.

ACCOUNTS

Of $3,232,850.00 appropriated by the State General Assembly for the operation of the Department of Public Health during the biennium ended June 30, 1945, there was an unexpended balance of $43,758.17 or a little more than one per cent. Of the lapsed sum, $20 000 was appropriated specifically for the establishment of mother's breast milk centers which, owing to war conditions could not be done during the biennium. Another item of $6,800 resulted from a vacancy in the position of Assistant Director and was not available to the Department for expenditure inasmuch as appropriations for salaries of State officers is made to the Department of Finance. Thus the lapse of expendable funds appropriated to the Department was $16,958.17.

The Federal government allotted to the State Department of Public Health for the fiscal year ended June 30, 1945 for general public health purposes, $1,231,709.27 of this amount $525,-236.00 was for general public health purposes; $380,422.03 for venereal disease control; $62,-250.00 for tuberculosis control; $263,801.24, for maternal and child hygiene activities. A substantial proportion of the funds obtained from Federal sources was reallotted to local full-time health departments. Of the money allotted by the Federal government $66,770.59 remained as an unexpected balance at the end of the year. Of this sum, $66,686.35 was from the Childrens' Bureau and earmarked for maternal and child hygiene services only. Owing to the shortage of personnel on the one hand and the overwhelming task of administering the FMIC program, the lapsed funds could not be used advantageously.

The Division of Maternal and Child Hygiene spent a major part of its strength in the administration of the Emergency Maternity and Infancy Care Program. The Congress appropriated funds to the U. S. Childrens' Bureau for the specific purpose of providing medical and hospital care for the pregnant wives and infants of enlisted men of specified ranks in the armed forces. The Childrens' Bureau had the responsibility of making the rules. The State Department of Public Health had the job of administering the project in Illinois. During the fiscal year ended June 30, 1945 a total of $2,263,619.73 was spent for that purpose by the State Department of Public Health in Illinois. Payment was made for medical and hospital care for 19,767 women and for 3,269 babies during the fiscal year.

THE PHYSICIAN'S RESPONSIBILITY IN BIRTH REGISTRATION

The Statutes relative to the registration of births and deaths which became effective in 1915 provide as follows in connection with birth registration:

"All births that occur in the State shall be immediately registered in the districts in which they occur, as hereinafter provided. The attending physician or midwife shall file a certificate of birth, properly and completely filled out, and in a form prescribed by the Department of Public Health, with the local or sub-registrar of the district in which the birth occurred within ten days after the date of birth. If there be no attending physician or midwife, then the father, or in case of death or absence of the father, the mother, and in the event of the death or disability of the mother, the householder where the birth occurred, shall file the certificate of birth with the local registrar within ten days after such birth; or if the birth occurred in a public or private institution, the manager or superintendent of such institution shall file with the local or sub-registrar a certificate of such birth, properly and completely filled out as herein required."

It is noted in the above provision that the birth attendant, either the physician or midwife, is required to file a certificate of birth "properly and completely filled out" within ten days after the date of birth.

During the period following this country's entrance into the war up to the present time people in all walks of life have been required to produce certifications of their birth records. Such certifications were necessary particularly where individuals were employed or desired employment in defense plants in connection with the war effort, or where they were entering some branch of the service.

Upon request the Department of Public Health, in those cases where there was a birth record on file, issued a certification of such record upon the payment of the statutory fee. In a great many cases these certified copies were returned to the Department with information that certain items shown by the certificate were incorrect and the certification was, therefore, of no value to the person because of that fact.

The principal incorrections noted were the spelling of surnames in the case of the individual himself and of his parents, and also a wrong given name or names. Other items that were in error were often times dates of birth and the birthplaces of the parents of the individual. Occasionally a record was returned because the sex shown upon the certificate was wrong. In some cases where the certificate showed the sex as female the name of the individual indicated that the item was incorrect.

Prior to July of 1943 there was no provision in the statutes that allowed the correction of birth records and consequently in many cases because of the fact that the certificate could not be corrected, the individual met with difficulty in obtaining employment or in entering some branch of service.

After the statutes were amended allowing the correction of records, such work became of paramount importance and required the full time of several employees of the Division of Vital Statistics.

Corrections of records were only allowed to be made upon the basis of affidavits and proof submitted that the record was in error.

A survey of these incorrect records clearly indicated that the birth attendant or the person completing the birth record had been careless and had not complied with the requirements of the law in seeing that the certificate was properly and completely filled out. The largest number of imperfect records were those where the births had occurred in a hospital. The reason for this appears to be that hospital attendants, that is, those employed in the maternity ward, assume the responsibility of completing the birth certificate insofar as possible upon the entrance to the hospital of the woman who is to be confined. After the confinement the routine procedure is, in most institutions, for the person in charge of the maternity ward or the assistant, to obtain the doctor's signature upon the birth certificate. In the majority of cases the physician, assuming that the birth certificate has been properly completed, attaches his signature without taking the precaution of checking the information on the record to ascertain whether or not it is correct. Therefore, a large number of certificates are prepared showing an incorrect spelling of the names. In addition to this sometimes a doctor will sign a certificate where the child is shown to be a female when in reality it is a male, or vice versa. It has also been demonstrated that in some cases the doctor has signed a certificate where the color of the child was in error, for

instance showing a child to be a Negro when in reality it was a white child.

Such errors now found in birth records could have been avoided if the physician had complied with the requirements of the law in seeing that the certificate was "properly and completely" filled out.

The responsibility of the physician in connection with births and his obligation to his client should not be considered terminated upon the delivery of the child. Physicians should feel obligated in all such cases, in addition to bringing the child into the world, to see that there is a proper birth record prepared for filing.

An individual's birth record may be considered as the deed to the name that he bears, and as he may be required to produce such document or deed in court or in various other places, the birth certificate should not contain any errors that would render it of no value.

As to preparing birth certificates in hospitals, where most of the errors arise, the Department of Public Health has considered a plan by which such mistakes could be minimized. This plan would require the person who prepares the certificate, prior to obtaining the doctor's signature, to present the certificate to the mother before confinement, or as soon as possible afterward, in order that she might survey the information on the certificate and in that way detect any errors in the spelling of names or with regard to other items required to be completed on the certificate.

After the certificate has been surveyed the prospective mother would be required to attach her signature at a designated place for the purpose of authenticating the information prior to the signing of the certificate by the physician and the filing of the certificate as a permanent record.

In the case of a birth occurring in the home, there are fewer errors to be found in the preparation of the birth certificate. The reason is that in the case of such births the doctor himself assumes the responsibility, as he should, of completing the birth record. Comparatively few birth records where the birth occurred in the home and the certificate had been prepared by the physician at the time of occurrence of the birth or immediately afterwards are returned to the State Department of Public Health for correction. This in itself is proof that if the physician will comply with the provisions of the statutes relative to birth registration and assume the responsibility personally of completing the certificate rather than leaving it to some other person, there will be many less errors and therefore less inconvenience and even losses in later life to the babies concerned and less cost to the taxpayers for the work involved in the correction of the birth certificates after they have been filed with the State Department of Public Health.

HEART REST AT SEA LEVEL

If you want to give your heart a rest, get down to sea level.

"Descent to sea level from a high altitude does afford some rest for the heart," the June 16 issue of *The Journal of the American Medical Association* explains in its Queries and Minor Notes department.

It is calculated that at 15,000 feet the heart works about 20 per cent harder to accomplish 20 per cent less work than at sea level. The pressure of the air at higher altitudes is much less than it is at sea level, and therefore the pressure of the oxygen which is breathed in is also decreased. For this reason, the heart has to work harder to supply the necessary oxygen to the tissues. Even climbing in a plane from sea level to 8,500 feet increases the work of the heart. However, *The Journal* says, "few instances of serious consequence, even in those who have heart disease, have ever been reported as a result of airplane flights."

Correspondence

REFRESHER COURSES STARTED AT UNIVERSITY OF ILLINOIS

Refresher and special post-graduate training for physicians and surgeons returning to civil practice from the armed services is under way at the University of Illinois College of Medicine.

The first one-week to three-month refresher courses for specialists already has been offered. The first three-month refresher course for general practitioners started Nov. 1 with 40 enrolled. Forty-six residencies for long-term specialist training and a number of research fellowships have been awarded.

The program, financed with the aid of a $90,000 three year grant from the W. K. Kellogg Foundation, is receiving nation-wide attention, according to Dr. Raymond B. Allen, dean of the University's colleges in Chicago. Wide interest is being shown by doctors in the services. Ten veterans have already enrolled for the second three-month course to be offered February 1.

The training was launched to help fill needs revealed by a survey of 21,000 doctors in uniform. Sixty per cent said that on demobilization they wished to take long-term courses leading to specialization, and more than one-fifth wanted short "refresher" courses before returning to civil practice.

The three-month basic training short course in medicine was planned especially for medical veterans planning to take up general practice, and consists of a review of important information in all of the specialties; particular attention will be given to the improvements in diagnosis and treatment discovered during the past few years.

Enrollment is limited to 40 at one time. Veterans will be given preference in enrollment, but civilian doctors also are eligible.

Dean Allen especially urges that "all graduates of wartime accelerated medical courses, who had only nine months of internship, should return for three or six months more of training in this type of course."

The University also is offering refresher courses for specialists. One-week courses in ophthalmology and in bronchoscopy already are under way. Other such courses may run up to three months in length.

These short courses are specifically refreshers and not to train specialists. Fields in which they will be offered, in addition to ophthalmology and bronchoscopy, will include pediatrics, obstetrics, internal medicine, surgical diagnosis, psychiatry, and orthopedics. Clinical and laboratory instruction will be emphasized in these courses.

To meet the demand for training new specialists, the university established 46 new residencies, which are appointments for doctors to live and work in University-connected hospitals to combine study and practice. These men have opportunity to specialize in any one of 15 fields. The University also established additional long-term research fellowships for specialist study.

PHI RHO SIGMA SCHOLARSHIP AWARDS

A year ago the plan for Phi Rho Sigma Scholarship Awards was announced, and the first awards were presented by Dr. Howard B. Carroll, president of the Medical Division, Northwestern University Alumni Association, and also, president of the Alpha Association of Phi Rho Sigma fraternity, at the Founders' Day con-

vocation held in the Archibald Church Library, Tuesday morning, October second, at ten-thirty o'clock.

The awards were made possible through the generosity of a loyal alumnus, Dr. George James Dennis, who did not wish to be named during his life time, but who did not live to see the fruition of his generosity. It was Dr. Dennis' desire that some stimulus for scholarship be made through his medical fraternity, and that a suitable tablet be placed in the Archibald Church Library as a constant reminder to this end.

A tablet, designed and executed by Miss Mary M. Webster, a noted sculptress, has been placed in the library. The plaque is in plaster now, due to present conditions, but is to be cast in bronze in the near future. Emblazened upon it are some of the works of medicine's immortal men, and there is space for the names of the recipients of the awards for many years to come; these names will be added annually.

There are three awards as follows:

The first award is presented to the student who has maintained the highest scholastic average during his first three years at Northwestern University Medical School. The award of one hundred dollars, and a certificate of recognition, was presented to Mr. Edward Vaughan Johnston, the recipient this year.

The second award is offered to the National medical fraternity at Northwestern University Medical School having thirty or more active members enrolled as regular students, which has maintained the highest scholastic average during the preceding year. The winning fraternity this year was Phi Delta Epsilon, and the fraternity received a framed certificate.

The third award is given to the man in the winning fraternity who has been chosen by his fraternity as the student to have contributed most toward winning the award. The man chosen by Phi Delta Epsilon was Mr. Nelson Lionel Portnoy who received an award of fifty dollars, and a certificate of recognition.

To the Members of the WOMAN'S AUXILIARY:

In a little less than twenty-seven years our nation is again entering a post-war era.

The work to be done with its responsibilities, efforts and planning, both mental and physical is tremendous as well as limitless. Of this great task, every profession, industry, organization, association, etc. must accept and do its share.

Since the organization of the Woman's Auxiliary to the Medical Profession, they have worked diligently and with success, and will continue to do so with increasing success. In order to accomplish the most good and thru the proper channels, we must have an incentive and a program. This is given us thru the medium of our own BULLETIN of the Woman's Auxiliary to the American Medical Association. Not only officers, but every member of the Auxiliary should be a permanent subscriber to this valuable publication.

The information of auxiliary aims, participation in community, state and national affairs, programs, suggestions and advice published therein is vitally necessary to all branches and members.

An efficient officer or member of any organization is always the well informed one. Are you?

Sincerely yours,
Mrs. Reinhold E. Johnson
BULLETIN Chairman

Medicine's Role in the War Effort

WORK OF MEDICAL DEPARTMENT IN WORLD WAR II

In his Biennial Report to The Secretary of War, General George C. Marshall, Chief of Staff of the United States Army, paid tribute to the Medical Department for its outstanding work in World War II, as follows:

"The remarkable reduction in the percentage of the deaths from battle wounds is one of the most direct and startling evidences of the great work of the Army medical service. In the last two years Army hospitals treated 9,000,000 patients; another 2,000,000 were treated in quarters and more than 80,000 000 cases passed through the dispensaries and received outpatient treatment. This tremendous task was accomplished by 45,000 Army doctors assisted by a like number of nurses and by more than one-half million enlisted men, including battalion-aid men, whose courage and devotion to duty under fire has been as great as that of the fighting men they assisted.

"One of the great achievements of the Medical Department was the development of penicillin therapy which has already saved the lives of thousands. Two years ago penicillin, because of an extraordinarily complicated manufacturing process, was so scarce the small amounts available were priceless. Since then mass production techniques have been developed and the Army is now using 2,000,000 ampules a month.

"Despite the fact that United States troops lived and fought in some of the most disease-infested areas of the world, the death rate from non-battle causes in the Army in the last two years was approximately that of the corresponding age group in civil life — about 3 per 1,000 per year. The greater exposure of troops was counter-balanced by the general immunization from such diseases as typhoid, typhus, cholera, tetanus, smallpox, and yellow fever, and, obviously, by the fact that men in the Army were selected for their physical fitness.

"The comparison of the non-battle death rate in this and other wars is impressive. During the Mexican War, 10 per cent of officers and enlisted men died each year of disease; the rate was reduced to 7.2 per cent of Union troops in the Civil War; to 1.6 per cent in the Spanish War and the Philippine Insurrection; to 1.3 per cent in World War I; and to 0.6 per cent of troops in this war.

"Insect-borne diseases had a great influence on the course of operations througout military history. Our campaigns on the remote Pacific Islands would have been far more difficult than they were except for the most rigid sanitary discipline and the development of highly effective insecticides and repellents. The most powerful weapon against disease-bearing lice, mosquitoes, flies, fleas and other insects was a new chemical compound commonly known as DDT. In December 1943 and early 1944, a serious typhus epidemic developed in Naples. The incidence had reached 50 cases a day. DDT dusting station were set up and by March more than a million and a quarter persons had been processed through them. These measures and an extensive vaccination program brought the epidemic under control within a month. Shortly after the invasion of Saipan an epidemic of dengue fever developed among the troops. After extensive aerial spraying of DDT in mosquito-breeding areas, the number of new cases a day fell more

than 80 per cent in two weeks. The danger of scrub typhus in the Pacific Islands and in Burma and China was reduced measurably by the impregnation of clothing with dimethyl phthalate.

"The treatment of battle neurosis progressed steadily so that between 40 and 60 per cent of men who broke down in battle returned to combat and another 20 to 30 per cent returned to limited duties. In the early stages of the war less than 10 per cent of these men were reclaimed for any duty.

"The development of methods of handling whole blood on the battlefield was a great contribution to battle surgery. Though very useful, plasma is not nearly as effective in combating shock and preparing wounded for surgery as whole blood. Blood banks were established in every theatre and additional quantities were shipped by air from the United States, as a result of the contribution of thousands of patriotic Americans. An expendable refrigerator was developed to preserve blood in the advanced surgical stations for a period of usefulness of 21 days.

"So that no casualty is discharged from the Army until he has received full benefit of the finest hospital care this Nation can provide, the medical service has established a reconditioning program. Its purpose is to restore to fullest possible physical and mental health any soldier who has been wounded or fallen ill in the service of his country.

"To insure that men are properly prepared for return to civilian life the Army established 25 special convalescent centers. At these centers men receive not only highly specialized medical treatment, but have full opportunity to select any vocational training or recreational activity, of both, they may desire. Men, for example, who have been disabled by loss of arms or legs are fitted with artificial limbs and taught to use them skillfully in their former civilian occupation or any new one they may select. Extreme care is taken to insure that men suffering from mental and nervous disorders resulting from combat are not returned to civil life until they have been given every possible treatment and regained their psychological balance."

★ ★

ARMY MEDICAL DEPARTMENT GETS SIX PER CENT OF WORLD WAR II DECORATIONS

Of the 1,400,409 decorations given in World War II in recognition of meritorious service and gallantry, six per cent were received by Medical Department personnel, according to a biennial report by General George C. Marshall. These figures are exclusive of the Air Medal and the Purple Heart.

NEW ORAL PENICILLIN TABLET

Hoffman-La Roche, Inc., of Nutley, N. J. recently announced to the medical profession Per-Os-Cillin—a new oral penicillin tablet. The advantages of this preparation are of considerable clinical significance. Due to the presence of special long-acting buffers in Per-Os-Cillin, the destructive action of gastric acid upon penicillin is inhibited and a therapeutically effective blood level of the drug is rapidly obtained—usually within 30 minutes after administration. Per-Os-Cillin is stable and retains its potency for a period of not less than 9 months. Like all oral penicillin preparations, Per-Os-Cillin should be stored at a temperature not exceeding 15° C. (59° F.). However, there is no likelihood of a loss of potency when Per-Os-Cillin is kept at room temperature for short periods. Thus ambulant patients can carry the prescribed daily dose in pocket or purse, if necessary. Per-Os-Cillin is available in the form of small, smooth tablets which are easily swallowed even by fastidious patients. Each Per-Os-Cillin tablet contains 25,000 units of penicillin calcium in combination with specially selected buffers.

To whatever school of social philosophy one belongs, the fact remains that it is the private physician who sees the largest number of persons in need of medical counsel. The physician knows by training and experience that the early manifestations of pulmonary tuberculosis are protean. A good percentage of his patients have one or more of these symptoms. Many others deserve x-raying on general principles because of physiological states conductive to activation of tuberculosis. William Courtney Douglass, M.D., NTA Bull., May, 1945.

Original Articles

PLASTIC PROCEDURES ABOUT THE EYES

IRVING PUNTENNEY, M.D.
CHICAGO

General Considerations. — In considering the subject of plastic procedures about the eyes, I will not bore you with an extensive array of operations for similar conditions or trouble you with lengthy detail on the steps in many operations. In my opinion, however, there are certain basic principles which will bear re-examination and if kept in mind a measure of success and satisfaction can be derived from their application.

Plastic repair in any case involves a careful examination of the defects with methods of reconstruction based upon an attempt to restore the normal anatomy and physiology. Special care should be taken to see that no new deformity is added during the operation and the technique must always be made as simple as possible. In order to visualize the necessary steps in reconstruction a few minutes can be spent profitably reviewing basic anatomy.

The lids are essentially a fold of skin, cutaneous on the out side and lined with mucous membrane on the inside. Structurally, however, they actually consist of four planes or layers of tissue: skin, muscle, fibrous tissue, and conjunctiva.

The skin is both delicate and elastic and since there is no sub-cutaneous fat it is loosely adherent to the underlying muscle. This causes it to wrinkle in old age and accounts for the ease with which edematous fluid collects in it in inflammatory states. The muscles concerned are: Orbicularis oculi, lid levator, and smooth muscle of Muller.

The Orbicularis muscle consists of concentric placed muscle fibers which may be divided into palpebral and orbital parts. The palpebral fibers arise from the medial palpebral ligament and run under the skin and terminate to form the lateral palpebral raphe. This part of the muscle is used in gentle closure of the lids as in sleep and blinking. *The fibers near the border are the ones that hypertrophy in spastic entropion.* The Orbital portion of the muscle arises from the medial orbital margin and acts voluntarily on forced closure of the lids.

The lid levator arises from the apex of the orbital and inserts with a wide aponeurosis to the upper surface of the tarsus and orbital septum.

The fibrous layer is composed of orbital septum and tarsal plate. The former consists of thin elastic and connective tissue and is attached to the periosteum around the orbital margin. It serves as a barrier to the extension of extravasation in either direction.

The tarsal plates are composed of dense connective tissue and conform to the shape of the eye ball. The upper plate measures 10 *to* 12*mm.* in breadth and being D-shaped it is narrower at its junction with the palpebral ligaments. The lower tarsus is about *5mm. broad* and band shaped, the ends being continued as the medial and lateral palpebral ligaments.

Special attention must be given to the palpebral or canthal ligaments because they serve as anchors for the lids and peculiar abnormalities arise following this disinsertion.

Presented before the Section on Eye, Ear, Nose and Throat, Illinois State Medical Society, 104th Annual Meeting, Chicago, May 16, 1944

Both the medial and lateral ligaments are formed by the junction of the upper and lower tarsus. The medial inserts into the periosteum of the anterior lacrimal crest and frontal process of the maxilla. The lateral ligament is attached to the orbital tubercle of the Zygoma within the mid point of the lateral margin of the orbit.

The arteries and veins are likewise to be considered as landmarks which are to be avoided for bloodless surgery. Fortunately there are only six arteries and four veins of particular importance. They are:

Arteries

1. Frontal
2. Nasal
3. Angular
4. Facial terminal Br.
5. Suborbital
6. Anterior branch of Superior Temporal

Veins

1. Frontal
2. Facial
3. Superior temporal
4. Angular

Injury to The Eye Lids with Special Attention to The Angles and Canthal Ligaments. — This brief review of anatomy will help in the appreciation of certain principles which must be kept in mind in the repair of lacerated lids and injury to canthal ligaments. One common injury is the tear in the lower lid which starts near the inner canthus and extends down through the skin and oribularis fibers to the lower margin of the orbit.

As Wheeler[1] has pointed out ectropion may result in the repair of such wounds if the flap is not carried upward and backward to a point of over-correction. This is first done by closing the conjunctiva with interrupted silk and then using heavier silk for the tarsus and skin. The sutures should remain six to seven days.

Another frequent injury at the inner angle is one which frees the insertion of the canthal ligaments. Sometimes only one tarsal insertion is cut at the commissure of the lids where the fibrous attachment of the tarsus joins the wider medial palpebral ligament. I recently saw a patient with this type of deformity following an automobile accident. The medial palpebral ligament had been re-attached but the tarsal insertion of the upper lid remained free and the relaxation allowed the inner ⅓ of the upper lid to ride over the lashes of the lower lid to produce a chronic irritation and conjuntivitis. A good repair may be achieved by re-attaching the ligament according to the method of Wheeler.[2]

The importance of the canthal ligament has been demonstrated in another patient with a disinsertion of the external canthal ligament. This occurred in an advanced case of blepharochalasis and a marked cosmetic improvement was achieved by re-attaching the ligament with buried white silk. This is not especially difficult if an elliptical incision is made in the skin at the outer angle and the tarsus of the upper and lower lid attached to the periosteum at the normal site of insertion with separate strands of white silk suture.

Occasionally the repair of an injury or a plastic procedure may be facilitated by severing one or both branches of the outer canthal ligament. This is applicable in accidents where the inner canthus becomes displaced temporally and forward and the caruncle and semilunar fold are no longer visible. The cutting of the external ligament allows sufficient relaxation to reattach the inner canthus to the periosteum of the anterior lacrymal crest.

Replacement of Skin. — There are three types of grafts which may be used for replacing lost skin. The first or full thickness graft was originally suggested by Wolfe[3] in 1876, but it never received much attention from the opthalmologists until John Wheeler demonstrated its great value in blepharoplasty. The graft should be taken from the skin of the upper eye lid and a piece as large as 16 mm. by 40 mm., and occasionally as much as 25 by 50 mm. may be taken without fear of removing too much.

When skin from the upper eye lid is not available or an insufficient quantity is present, the next best is skin from the cephalo auricular angle. In extensive burns additional full thickness grafts may be taken from the inside of the thigh or flexor surface of the arm. The skin from the latter source is not desirable, however, as it is too thick, lacks elasticity and does not match as to color and texture. In cutting these grafts it is best to excise the skin either with a sharp Graefe knife or scissors, care being taken not to pinch the graft. Sometimes a traction suture can be used to good advantage when cutting the graft and any excess of connective tissue and fat

should always be removed before suturing in place.

The second type of graft is known as a pedicle flap and may be either of the sliding or interpolated type. Some men prefer them for the repair of defects but anyone who believes in the dictum that no new disfigurement should be added by the operator will naturally be a bit startled by the facial scars shown by Blaskovic, Imre, and others. In general, it may be said that pedicle grafts should be reserved for those cases in which there is a poorly nourished bony surface, a bone injury near the orbital margin with a scar filled base, insufficient conjunctiva and contracted sockets. When a pedicle graft is to be used, it should be secured from neighboring parts. Although each case is individual, there are three types that can be used to advantage.

The third type of graft is known as the epidermic graft and when properly cut it includes the superficial and deep layers of the epidermis. Considerable care and skill together with an extremely sharp razor is needed for the successful removal of such a graft. Most authorities agree that epidermic grafts should be reserved for extreme burns where it is impossible to use full thickness grafts.

Ectropion. — Ectropion is a condition in which either the upper or lower eyelid is everted so that the tarsal conjunctiva is exposed. With the exception of certain post-operative cases, it is convenient to divide ectropion into: Atonic, spastic, and cicatricial forms.

Atonic ectropion occurs in the lower lid, either from the relaxation of the orbicularis muscle as in seventh nerve paralysis or from the atrophy of the skin in patients past middle age. The latter is usually called senile ectropion and the overflow of tears, itching and irritation often becomes very troublesome. In very marked cases an exposure or lower marginal keratitis develops together with a muco purulent form of conjunctivitis.

The treatment is surgical. Ziegler's cautery puncture works well when there is only a slight eversion of the lid. A series of cautery punctures is made in the conjunctiva of the lower cul de sac 4 mm. below the lid margin and approximately 3 mm. apart. Care should be exercised so that the galvo-cautery penetrates the tarsal plate but does not pass through it.

In well advanced cases it is necessary to adopt a more radical procedure which usually means the resection of a portion of both tarsus and skin according to the method of Adams, Kuhnt, Miller, Blaskovic, Sattler, and others. Most of the procedures are a modification of Kuhnt's method in which a wedge-shaped piece of tarsus and conjunctiva, the apex of the wedge being downward, is removed from the lid. The redundant skin can be eliminated by the application of either Wheeler's[4] halving principles or the excision of a base up triangle of skin at the outer canthus according to the Szymanowski[5] modification.

In either case it is necessary to separate the skin and tarsus at the white line and continue the separation to the external canthus.

Spastic ectropion results from blepharospasm and is usually associated with severe conjunctivitis and orbital disease. Surgery should never be attempted until the exciting cause has subsided and then a semi-pressure dressing applied to the eye for several days is usually sufficient.

In 7th nerve paralysis a blepharoplasty may be performed at the outer angle. This shortens the fissure and holds the lower lid in better apposition. If the relaxation is great enough a fascia lata sling may be used.

Cicatricial ectropion occurs more frequently in the lower lid and may develop following burns and traumatism in which there is a loss of tissue with subsequent scar contraction.

The treatment is surgical and consists in the removal of the scar tissue with the freeing of adhesions so the lid may return to its normal position. The lost skin should be replaced with full thickness lid or cephalo auricular grafts. The area that is to receive the graft must be prepared with care and all bleeding points stopped. Two inter-marginal adhesions are then made between the upper and lower lid.

This procedure is not difficult if a sufficient amount of tissue is removed at the lid borders with the denuded areas meeting at opposing points. The raw edges are then approximated by a horizontal mattress suture tied over small pieces of rubber tubing. Failure to produce adhesions is usually the result of removing too little epithelium and underlying tissue. Little difficulty will be encountered if the lid margin is grasped with a muscle advancement forceps and

the tissue removed with a ground down cataract knife.

The size of the skin transplant may be determined by cutting an oiled paper pattern with a dimension slightly larger than the defect. Points on the graft should be avoided and interrupted fine black silk used to suture the skin in place.

When a pedicle graft must be used it should be secured from neighboring parts. There is seldom a need for it in cicatricial ectropion save in the few cases where a good bed cannot be prepared to receive the graft. An example of such a case is a deep wound below the eye with bone injury near the orbital margin and scar tissue that has partially filled in the depression. A flap can be turned down from the temple or forehead and the thickness gauged by the depth of the defect that must be filled.

Entropion or a turning in of the lid is usually associated with trichiasis and may be divided into spastic and cicatricial types. The former is caused by a spasm of the orbicularis muscle and may become chronic when there is a hypertrophy of the orbicularis fibers near the lid margin and aggravated by a relaxation of neighboring tissues as in old age. Ziegler's cautery puncture and taping have been recommended for the intermittent forms, but in the chronic cases, permanent results can be achieved more readily by the excision of a portion of muscle and skin, according to the method of Hotz.[6]

This is done by making an incision through the muscle fibers and skin parrallel with and 3 mm. from the lid border, extending to within 5 mm. of the inner and outer canthus. An elliptical incision is made below it so that an area of skin and orbicularis 3-4 mm. wide may be removed. The secret of the operation is to pick up this tissue and remove all the muscle fibers down to the tarsus and after undermining the skin next to the lash border to remove the hypertrophic muscle fibers up to it. Three sutures are then placed through the skin and tarsus. There is a tendency when first performing the operation to remove too little skin and muscle tissue.

In the cicatricial form of entropion there is usually a distortion and contraction of the tarsal conjunctiva and plate with trichiasis which in severe cases may produce a chronic kerato-conjunctivitis. The treatment is always surgical and directed toward a straightening of the tarsal plate, restoration of the normal position of the cilia and prevention of the recurrence of the condition. In mild cases it is occasionally possible to use a Hotz stitch but when there is much contraction and trichiasis it is far safer to employ a technique which will straighten the tarsus and restore the cilia to the outer edge of the lid. Streetfield, Blaskovic and others have described numerous procedures but none have been found, in my opinion, to excell the operation of Van Millingen as modified by Doctor Harold Gifford.[7]

In this procedure, the lid border is slit along the white line, care being taken not to damage the lash bulbs and to keep them on the skin side of the incision. If there is a marked rolling in and contraction of the tarsus, a narrow wedge-shaped incision may be made through the most curved part and a strip about 1 to 2 mm. in width removed.

This allows the tarsus to relax and lessens the concavity. Sutures are then placed as shown in the slide and the defect filled with a thin mucous membrane graft taken from the inside of the lip.

No attempt need be made to suture the graft in place but care should be exercised in getting good apposition between the tissues and the graft. A small wisp of moist cotton covered with vaseline is placed directly over the graft and the whole eye covered with a semi-pressure dressing.

Colobomas of the lid. — Colobomas of the lid may be divided into congenital and acquired. When the defects are small, most of them can be repaired by the use of the Wheeler[8] halving principle. This consists in closing the skin and underlying tissues in different planes. This adds security to the wound when it is under tension and produces minimal scarring at the sites of the incisions. If we assume that the deformity is in the upper lid, the mass of scar tissue around the laceration of the tarsus must be excised and the tarsal flaps cut straight across to give even apposition.

A slight over-correction of the notch may be achieved by making the tarsal flaps slightly shorter above than below. The skin and underlying orbicularis are then cut to make a sliding flap on one side and a rectangular area of tarsus is exposed on the other side. An external can-

thotomy can be performed on the upper tarsal ligament if the lid is too tight. A triangular piece of skin and under-lying tissue should then be removed to prevent puckering and the tarsus and conjunctiva sutured with three interrupted chromic sutures. If silk is used and tied on the conjunctival side, some difficulty may be encountered when an attempt is made to remove them. A mattress suture is carried through the triangular area of exposed tarsus, out through the flap, and tied over small pieces of sterile rubber tubing. The mattress suture should be removed after three or four days. If additional splinting is necessary, the lid margin may be sutured together or held in place for a longer period of time with inter-marginal adhesions.

When larger defects are encountered, the lost tissue must be replaced by pedicle flaps or combind with a reverse Hughes'. The latter procedure will be discussed later, the results being superior to many methods now in general use.

Taro-Conjunctiva grafts. — Taro-conjunctival sliding grafts for lower lid reconstruction all start by partially or completely separating the upper lid into two layers: a taro-conjunctival and a skin orbicularis layer. This must be followed by the removal of the epithelium from the lid border.

When the conjunctiva of the lower lid is still present, Landolt's[9] method may be used. This consists in suturing the free end of the conjunctiva between the two layers of the split upper lid and joining the skin of the upper lid to the skin of the defect below. This is not good, however, because the splitting of the tissues at a later date moves the lashes of the upper lid to the lower lid.

Dupuy-Dutemps[10], to avoid this, completely separated the upper lid into two layers and sutured the conjunctival edge of the lower stump to the free edge of the upper tarso-conjunctival layer. The skin and muscle layer was then pulled down and sutured to the skin border of the lower defect. Several weeks later the skin was incised just below the ciliary border, returned to its old position and the tarso-conjunctival layer covered with a pedicle flap from the upper lid. Four weeks later the lids were separated by a through and through incision below the ciliary border. This procedure is quite satisfactory but I believe the skin pedicle would take if sutured in place during the first stage of the operation.

Hughes'[11] modified the Dupuy-Dutemps' operation by substituting the skin of the cheek for the pedicle graft from the opposing lid. The various stages are shown in the following slides.

For blepharoplasty of the upper lid, good results may be obtained by using a reverse Hughes'. This is essentially the same as the original Hughes' operation, but the lower lid rather than the upper is split and approximately one-half of the lower tarso-conjuctival layer transplanted to the upper lid. Excellent results may also be achieved by the procedures recently described by McLean[12] and by Sugar[13].

In partial defects of the upper and lower lid where not more than ⅓ of the tarsus is missing, a Kuhnt[14] sliding tarso-conjunctival flap may be used. This flap is prepared by making two vertical incisions through the conjunctiva and tarsus of the opposing lid, the incisions beginning at the margin of the lid and extending at least ½ cm. beyond the tarsus. This tarso-conjunctival pedicle is then shifted to fill the tarsal defect, two inter-marginal adhesions being placed on each side of the sliding graft. The skin defects may be filled by either a vertical or a horizontal sliding flap, the horizontal being preferred as it fulfills the principles of Wheeler's halving operation. Some cosmetic improvement can be secured by the transplantation of lashes, according to Wheeler's method. This should always be done before the final separation of the adherent lids.

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INDICATIONS AND CONTRAINDICATIONS TO GASTROSCOPY

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Since the introduction of gastroscopy as a diagnostic procedure, many controversial problems have arisen. While many of them primarily concerned the gastroscopist, the internist and general practitioner are primarily concerned on which patient this procedure should be used. What are the indications for its use and finally what diagnostic information can be obtained by this method of examination? The medical man also wishes to know whether this approach is superior to roentgenological examination. Finally, is this method safe and do the results warrant the discomfort and dangers which may arise. I will attempt to answer these questions by reporting my experiences in gastroscopy both here and abroad in a large number of patients.

I will attempt to take a midline course between those who are overly enthusiastic and those of us who are trying to be conservative in our clinical evaluation.

The term "gastroscopy" is used to denote a procedure by which a combined light and optic system enclosed in a rigid or semi-flexible tube, is introduced into the stomach by mouth. The optic system having an objective at one end, and an ocular on the other, renders it possible to inspect the living mucosa and to detect surface changes inaccessible to other types of examination.

Gastroscopy is by no means a new method; its history started with Kussmaul in 1886 who, experimenting with a sword swallower, conceived the idea that it must be possible in every human being to straighten the passage from the upper teeth, esophagus and cardia into a direct line and to introduce an instrument into the stomach. Kussmaul lacked the optical means to succeed in the inspection of the interior of the stomach, but about 15 years later the Polish surgeon Mikulicz-Radecki built the first usable instrument and from that time progress was more rapid. New instruments have been devised by Loening and Stieda, by Elsner, and many others, but all these gastroscopes were relatively dangerous instruments, because of their size and rigidity, and many fatal esophageal ruptures were produced. Therefore, gastroscopy remained an experimental method in the hands of a few skilled workers. But these few enthusiasts stuck to their guns and, thanks to the persistence of such men as Elsner, Schindler, Gutzeit, Hohlweg, Korbsch, and Moutier, gastroscopy was developed into a routine method; its mechanics were studied, numerous endoscopic observations were described and compared with clinical symptoms and thus a well founded experimental and clinical material has been accumulated.

In 1932, the flexible Wolf-Schindler instrument was invented and the biggest objection to gastroscopy, the peril of perforation, even in not very skilled hands, has been practically removed. Gastroscopy spread all over the world and became a routine examination in all larger and well equipped hospitals.

But to be sure, the Wolf-Schindler instrument is not yet the ideal solution for the process of a complete inspection of the stomach; there are still defects of mechanical and optical nature in this instrument, which have to be removed before the final perfection will be achieved.

Without going into details of the optical or mechanical problems of gastroscopy, one thing seems to be important enough to be mentioned here, and that is the actual position of the instrument in the body during gastroscopy. The understanding of this problem may help to explain the difficulties of gastroscopic examination which are due to intricacies of the anatomy of the human stomach. Compared with the endoscopy of other organs, gastroscopy and the interpretation of its results is rather complicated.

The route by which the instrument is introduced is the pharynx, the tortuous esophagus, and the sharply bent cardiac entrance. This passage limits naturally the mobility of the gastroscope to up and down movements and to a rotation along the axis of the instrument; lateral excursions are minimal and, because of the narrowness and fixation of the esophagus, dangerous.

The cavity of the stomach being asymmetric, tapering towards the pyloric end, and having a more or less pronounced angulation in the middle of its body, and lying bent over the spinal column, is a further obstacle to a centric placement of the instrument. All these factors force the gas-

Gastroscopist at Michael Reese Hospital and Mount Sinai Hospital, Chicago, Presented at Stomach Group Seminar of Michael Reese Hospital on January 20, 1944.

troscope into a definite, fixed position at the cardia and close along the left side of the spinal column on the posterior wall of the stomach; when pushed downward, the tip of the gastroscope hits the larger curvature near the beginning of the antrum.

The idea that the flexible scope is able to slide smoothly along the larger curvature into the antrum is a false one. Numerous x-ray examinations have revealed that the flexible end of the scope after having passed the cardia, regains its former straight shape and behaves like a rigid gastroscope.

When the gastroscope is in its position, air must be blown into the stomach in order to detach the mucosa surrounding the objective and so to permit the objective to collect the incoming rays and to pass them along the tube to the ocular.

Knowing these simple facts it is easy to understand why the prepyloric region of the small curvature, the most important territory in gastric pathology, is often hidden behind the angulus and why it is impossible to visualize in any case the upper part of the smaller curvature, small parts of the anterior wall and larger parts of the posterior wall and of the fundus. These parts are either out of the field of vision, or their mucosa cannot be detached sufficiently from the objective in order to be visualized.

For the same reasons biopsies are possible only from limited areas close to the objective, that is from the posterior wall, which may not be representative of pathology in other parts of stomach. Biopsies are not justified under present circumstances, and I do not believe that they will become a routine procedure even with improved instruments. The peculiar anatomy of the stomach will frustrate such attempts.

In order to eliminate the mentioned invisible areas or the so-called blind spots, a new type of a modified rigid gastroscope has been devised by Korbsch several years ago and lately has been copied here. According to my experience and in agreement with a number of well known gastroscopists this instrument, which is provided with an exchangeable prograde, orthograde and retrograde vision, proved to be superior in every respect to the flexible scope. Although not ideal in all details it constitutes a definite progress towards the total inspection of the gastric mucosa and, although rigid, because of its small caliber it is just as safe as the flexible instrument in the hands of a skilled examiner.

What are the indications for gastroscopy?

As a general rule, no patient should be gastroscoped before complete clinical, laboratory and x-ray examinations have been made. Gastroscopy should be a final examination, performed when a careful clinical study has left some doubt regarding the diagnosis or the further therapeutic procedure. Only in such cases is gastroscopic examination justified, and may be of value both to the patient and to the examining physician.

Gastroscopy can and should be performed on patients with positive or with negative findings only when the following indications are present.

1. When there is a long standing history of obscure abdominal complaints with negative physical, laboratory and x-ray studies. Small, shallow gastric lesions, not detected by x-ray, are not infrequently found.

2. Neurotic patients with dyspeptic symptoms, but without positive findings on repeated examinations should be gastroscoped before being sent for psychotherapy. Early carcinoma has been found in some of these so-called neurotic patients.

3. A patient with unexplained loss of weight, loss of appetite, or persisting nausea, may have an early gastric carcinoma not apparent yet on the x-ray film.

4. Patients with unexplained hematemesis or melena when gross hemorrhage has subsided for a safe period of time should be gastrocoped, because small shallow bleeding ulcers, gastric erosions, hemmorhages from gastritis or even a high carcinoma of the corpus have been found not infrequently.

5. Patients with positive x-ray findings or definite gastric pathology, should ge gastroscoped in order to confirm a difficult or a doubtful diagnosis, or to aid in the differential diagnosis between a malignant and a benign ulceration. I do not believe that, except in the pre-pyloric region of the smaller curvature, there is a frequent incidence of benign ulcers of the stomach which become malignant later; I am sure that in cases in which this will occur, gastroscopy cannot be of much help in the early recognition of a malignancy. The gastroscopist finds it equally as

difficult as the pathologist to differentiate the benignancy or malignancy of a given lesion from gross observations in a borderline lesion. Parenthetically it may be stated that pathologists have difficulties at times in arriving at an exact diagnosis from the microscopic examination of the excised tissue.

The primary malignant ulcers which in their early course often simulate the symptomatology of a benign ulcer are sometimes diagnosed as malignant by gastroscopy at a time when the roentgenologist does not suspect anything. There are recent reports that a malignant lesion will heal superficially under ulcer management, but later will break down in spite of this management. It is reasonable to assume that some of these cases would have been picked up by gastroscopy because of the increasing carcinomatous infiltration of the floor of the ulcer, at a time when the niche had disappeared roentgenologically.

6. Patients with complaints after gastric resection or anastomosis are the most gratifying cases for gastroscopic examination. Poor functioning, or ulcerations at the stoma, not visualized by the x-ray, and the most severe and extensive gastritic changes are explanations for the absence of relief by the operation in these patients.

7. If a clinical and x-ray diagnosis of gastric malignancy has been made, gastroscopy may often aid in determining the possibility or the extent of resection. Excessive inflammation of the gastric mucosa surrounding a malignancy may simulate extensive invasion of the gastric wall on the x-ray film, while gastroscopy may help to reveal that the malignancy is more limited and resection is still possible.

8. A healed gastric ulcer in which the niche has disappeared at the final x-ray examination should have a gastroscopic follow-up when the lesion is in an area accessible to visualization. Ulcers believed to be healed by clinical and x-ray evidence may still show activity gastroscopically. These are the cases which later are thought to be the recurrence of an old ulcer or a new malignancy, but which are only a continuation of the primary process. The benefit of an examination is very obvious.

9. If the diagnosis of a duodenal ulcer has been made and if a resection is contemplated, a preliminary gastroscopic examination is, in my opinion imperative. It is believed that the presence of severe gastritis is the cause for poor postoperative results (Gutzeit and Korbsch). I am sure that, in a number of cases, a preoperative gastritis has been present and that adequate medical treatment might have prevented postoperative complications. No surgeon would ordinarily perform an extensive operation in an area of inflammation. Therefore, there should be no justification for operations in the presence of extensive gastrititis when the operating procedure is an elective one.

10. In patients with pyloric obstruction in whom a definite x-ray diagnosis of the underlying pathology is often very difficult, gastroscopy may be of value.

Cases of gastritis are fascinating subjects for gastroscopy from the point of view of research. For all practical purposes, gastroscopy gives very little aid in this disease and has a definite value only in a small number of cases, especially in post-operative ones. Thanks to gastroscopy we know today that gastritis is more often found in the human stomach than was ever believed formerly. But in spite of the piling up literature and of extensive studies, nothing conclusive has been achieved and none of the problems of gastritis have been settled. I do not feel that the classification of different types of gastritis is of clinical or of practical value. Up to date no definite correlation between the gastroscopic, the x-ray and the pathological findings has been established. Severe gastritic changes found by gastroscopy are compatible with complete lack of subjective symptoms and with perfect well being, while on the other hand in some cases with so-called typical gastric symptoms, no pathology whatsoever may be present at a gastroscopic examination.

I have questioned the clinical significance of chronic gastritis from a practical point of view for years. Even the recent and somewhat better founded reports of the alleged relationship between atrophic gastritis, pernicious anemia and gastric cancer are still so vague that I did not change my opinion in this matter.

I believe that superficial and hypertrophic gastritic and peptic ulcer, as described today, are probably different expressions of the same disturbance, which will manifest itself clinically

only when a threshold for the production of pain or discomfort in a given individual has been reached.

What are the contraindications for gastroscopy?

1. Seriously ill, febrile patients should not be gastroscoped.

2. Patients with bronchitis or other pulmonary conditions associated with cough and dyspnea should not be gastroscoped.

3. Patients with aortic aneurysm, with stenosis or obstruction of the esophagus with esophageal carcinoma, with varices or diverticula of the esophagus, or with cardiospasm, should not be gastroscoped.

4. Angina pectoris, severe distortion of the spine and psychosis, are strict contraindications to gastroscopy.

Does gastroscopy compete as a method with x-ray examination?

From my former statements you can already conclude that this is not the case. Basically, the x-ray examination is a more valuable and superior method than gastroscopy in diagnosing major and minor changes of the stomach, in visualizing all parts of the stomach and in information given about the peristalsis and functional capacity of the organ. The smaller and the superficial alterations of the gastric mucosa are better demonstrated with the gastroscope, and for this reason the gastroscopic examination is able to supplement x-ray studies, but never to replace them. Close collaboration between gastroscopists and roentgenologists will lead to a better and more satisfactory diagnosis in doubtful cases.

Can gastroscopy be recommended as a safe method and is the discomfort associated with it worthwhile accepting it?

Gastroscopy with the flexible and even with the rigid instruments of today is a perfectly safe method and many thousands of examinations have been performed without mishap. The few reported accidents were produced by peculiar circumstances which probably could have been avoided. I do not share the opinion of some that a gastroscope must be so safe that it can be put into the hands of any physician who wants to use it. Such instruments will never be developed.

The discomfort allegedly associated with a gastroscopic examination is so minimal with a good local anesthesia, that it cannot be an objection in indicated cases.

ORBITAL PROPTOSIS

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Protrusion of the eyeball occurs often enough in ophthalmology, otolaryngology and general medicine to warrant a discussion of the subject.

Most acute inflammations or rapid swellings which may simulate or produce proptosis such as osteomyelitis, orbital abscess from acute sinusitis, cavernous sinus thrombosis and trauma, offer little difficulty in diagnosis, as other manifestations of the disease are present. These will not be included in the discussion.

Exophthalmos may be unilateral or bilateral. There are a few conditions which produce bilateral involvement of the orbits such as that associated with thyrotoxicosis and other systemic disorders. Unilateral proptosis frequently taxes one's diagnostic acumen to the utmost. The problem of ocular proptosis may be approached best from the standpoint of possible anatomic origin, that is, whether or not it arises from general disease or from a distant part of the body, paranasal sinuses and skull, cranial cavity, or within the orbit itself.

A. Proptosis from systemic causes or growths in distal areas.
 1. Proptosis associated with thyrotoxicosis
 2. Xanthomatosis
 3. Metastatic growths
 (a) Neurogenic — especially from the medulla of the adrenal, and sympathetic ganglia.
 (b) Malignancies — lung, prostate, breast and thyroid
 4. Lymphatic leukemia
 5. Chloroma
 6. Syphilis

Exophthalmos associated with hyperthyroidism usually occurs bilaterally, although it may be unilateral. Formerly, it was the concensus of opinion that toxic goitre was the primary cause. Recent experimental and clinical in-

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vestigation has indicated that the anterior lobe of the pituitary, which secretes the thyrotropic hormone, plays the primary role in producing this condition, with the thyroid of only secondary importance. Smelser,[1] Reese,[2] Thomas & Woods,[3] Jensen,[4] Friedgood,[5] Covitz,[6] Hertz and associates,[7] presented cases where exophthalmos had preceded the tremor, increased B.M.R. and other signs of thyrotoxicosis. Significantly, these investigators have proof that malignant exophthalmos may follow thyroidectomy. The proptosis is the result of edmatous fibrosis, muscle degeneration and cellular infiltration of the ocular muscles which tend to push the globe forward. It is assumed that malignant exophthalmos is due to excessive anterior pituitary action, or at least to an unbalance between the pituitary and thyroid since exophthalmos has been produced in animals by high anterior pituitary dosage and improvement in some malignant proptosis by thyroid extract administration.

The ordinary signs of exophthalmic goitre such as tachycardia, hypertension, heat intolerance, increased B.M.R., Stellwag's and Graefe's signs are not present in malignant exophthalmos. There is a marked lid thickening, chemosis, diplopia, conjunctival symptoms, epiphoria and usually a rapid onset of bulbar protrusion.

Treatment for thyrotoxicosis should receive the attention of the internist or surgeon. Thyroidectomy is not indicated for exophthalmos unless toxicity is present and uncontrollable. Irradiation of the pituitary gland has been beneficial in some cases of malignant exophthalmos; thyroid administration and iodine have aided in reducing the proptosis. In other patients, it has been necessary to perform surgical procedures in order to overcome the extreme exophthalmos. Palliative treatment consists of tarsorrhaphy, canthotomy and relaxing excision of the orbital fat. More radical operative procedures consist of Naffziger's transfrontal type with orbital and optic canal decompression, or Sewall's removal of frontal sinus and ethmoid cells.

Xanthomatosis may produce proptosis if it involves the skull. This disease usually has its insidious onset in childhood. Microscopic study of the granuloma-like mass reveals pale ovoid cells with pyknotic nuclei and lipoid droplets — so called foam cells. Schuller-Christian syndrome is a generalized form of idiopathic xanthomatosis affecting the skin, aponeurosis, visceral organs and bones. It is characterized by defects in bones, diabetes insipidus and proptosis. Irradiation has offered the most therapeutic benefit.

Most of the neurogenic tumors migrating to the orbit arise from the sympathetic nervous system, especially the adrenal and sympathetic ganglia. They finally manifest themselves in the flat bones of the skull, proptosis and ecchymosis of the lids. There is moderate anemia, loss of weight, and intermittent fever. Soft vascular tumors occur about the skull with dilatation of superficial veins of the scalp. Palpable tumors eventually become evident in the kidney and liver regions. The long bones and ribs may become involved. X-rays show a worn eaten appearance. Metastatic malignancies occasionally occur from the prostate, breast, lung and thyroid. These organs should be investigated as a possible source of orbital tumors if no other cause can be found.

According to Reese and Guy,[8] proptosis occurs in about 2% of lymphatic leukemia cases. The commonest ocular manifestations are retinal and conjunctival hemorrhages, puffiness of the eyelids and pale milky appearance of the fundi and blood vessels. A generalized lymphadenopathy is present. There is a very high leukocytosis with the differential count showing a marked lymphocytosis.

A few cases of chloroma have been reported in which bilateral exophthalmos has occurred, Derer and Friedman.[9] The lids become edematous. The fundi show venous stasis; the liver and spleen and lymphatic glands are enlarged. The blood picture is that of myeloid leukemia. Tumor masses showed a greenish color and were diagnosed as chloromyeloma. Gump and associates[10] also reported that gingivitis, diminution in vision and hearing occurred and that the monocytes varied from 20% to 60%.

Most of the reported cases of tertiary syphilitic proptosis have been unilateral. There is pain and impairment of one or more of the motor nerves of the eye. The most common site is the orbital apex or superior wall of the orbit. Ptosis may be present. Other signs of leutic infection will aid in making a diagnosis.

B. Lesions of the Paranasal Sinuses and Skull Invading the Orbit.
 1. Malignancies
 (a) Carcinoma — particularly of the ethmoid and sphenoid
 (b) Lymphosarcoma from epipharynx and lateral pharyngeal wall
 2. Benign growths
 (a) Osseous lesions of nose and sinuses
 (b) Mucocele
 (c) Nasopharyngeal fibroma
 (d) Xanthomatosis and cholesteatoma

Thorough history, physical examination, biopsy, laboratory investigation and x-ray of the sinuses are paramount in determining the cause of orbital proptosis. It is helpful to carefully examine the position and movements of the globe. If the break through into the orbit is from the sphenoid or posterior ethmoids, the proptosis is primarily forward; if from the frontal sinus, the eyeball is depressed and may be proptosed with limitation of upward movement. When the lesion arises from the anterior ethmoids there is a greater lateral deviation with restriction of internal movement of the orbit. Tumor masses from the maxillary sinus will tend to push the eye upward and forward if the break through is rather far back in the orbital floor.

Diagnosis of malignancy of the sinuses is usualiy quite evident by the time proptosis of the eye has occurred. The characteristics of the hyperplasia of tissue, recurrent bleeding and with rapid regrowth after removal from the sinus is almost diagnostic in itself. However, early microscopic study should always be done so that radical operative procedure and irradiation can be instituted.

Case Report: Male, age 24; in good health except for a left nasal blockage and nasal discharge. Examination revealed cloudiness of the left ethmoids and sphenoids by transillumination and x-ray. There was moderate hyperplastic tissue in the left ethmoid region which bled easily. Biopsy revealed chronic inflammation. Ethmoidectomy and sphenoidectomy was done and all of the tissue sent for laboratory examination. Pathologic report was carcinoma Grade III. Heavy irradiation was done but in spite of this a marked exophthalmos occurred and an invasion of the frontal sinus and brain. Early radical operation was refused by the patient and the patient died three months later with brain metastasis.

The osseous growths are benign, grow slowly, usually cause little or no deformity or discomfort until extremely large. Erosion of the thin bone separating the sinuses and the orbit eventually produces a displacement of the globe and interference of ocular movements. Most orbital osteoma have their origin in the frontal or ethmoid region. Trauma seems to be the commonest etiological factor and usually occurs in youth and early adult life. Smith[11] and others are of the opinion that this tumor is closely allied with both the giant cell tumor and osteitis fibrosa.

Mucoceles of the ethmoids and frontals may produce the same symptomatology as osteomatous growths, but can be differentiated by the marked bone density of osteoma as seen by x-ray. When the mucocele has broken through into the orbit, the fluctuant character of the tumor can be felt. Surgical removal is the treatment of choice for both conditions.

Nasopharyngeal fibroma is a rapidly growing vascular, fibrous tumor originating in the epipharynx from the base of the skull. Most of these tumors occur in the adolescent period and although benign, they may invade the ethmoids and orbit. The tumor is sensitive to irradiation with radium or x-ray. Surgical removal can be done later if necessary.

Xanthomatosis has been discussed under systemic disease and is mentioned here again because the only manifestation of lipoid metabolism disturbance may be a tumor mass in the sinus and orbital region. Knapp[12] discussed orbital xanthomatosis ten years ago.

Cholesteatoma is a rare condition of the sinuses and skull. It produces destruction by pressure and may invade the orbit. There is so little in the literature about this disorder, with the exception of secondary cholesteatoma occurring in chronic suppurative otitis media and mastoiditis, that I am presenting a recent case:—

D.W.: Age 26. The only history that might have any bearing on the development of this condition was a blow over the left eye causing a laceration when he was 5 years of age, which was taken care of by the family physician. While he was still quite young the left eye began to bulge and has become gradually worse. He has not been subject to headaches or dizziness. There are some symptoms of eye strain after prolonged use of his eyes. There has been no complaint of nasal obstruction or discharge. Examination revealed a marked exophthalmos of the left eye with the lids barely covering the globe. There was no

inflammation of the lids or dystrophy of the cornea. Vision in the right eye was 20/20; the left eye fingers at 8 feet. The eye was markedly depressed below the level of the right eye with limitation of vertical movement. A firm tumor mass was palpable above the left eye and a small round mass about 3 cm. above the eyebrow in the temporo-frontal region of the frontal bone. The remainder of the physical examination was normal, including a neurological study. All laboratory investigation was normal. X-ray of the skull and sinuses revealed the roof of the left orbit almost gone with a round bone defect at the upper outer angle. The left frontal sinus and ethmoids showed cloudiness. There was no evidence of endocranial pressure. An external frontoethmoid incision was made in order to obtain a biopsy and exploration. The orbital edge was irregular. A large tumor mass of firm pale cheese-like material was found extending above and behind the globe. The floor and posterior wall of the frontal sinus was completely gone. This mass came out in regular onion layer peelings. The dura was thin but otherwise normal. There was none of the mass in the ethmoids but an ethmoidectomy was done in order to give good drainage. Pathologic report was cholesteatoma. Four months later an external frontal operation was performed with the incision carried up at the outer tip of the eyebrow up in the temporo-frontal region to completely eradicate the cholesteatoma from behind the eye and skull. The orbital contents were deflected down and inward and temporal muscle reflected outward. The remaining mass was removed by spoon and bone biting forceps where erosion had taken place through the lateral orbital wall. A tract led from the orbital ridge up to the round area in the fronto-temporal region which was removed. There was no evidence of chronic osteomyelitis. The entire cavity was thoroughly curetted and irrigated with saline and antiseptic. The cavity was partially filled with iodoform gauze which was brought out through the nose and primary closure of wound was made. Counter pressure was used over the eye as the gauze was removed. Pathological report was cholesteatoma. Vision is now 20/40 and correctible to 20/20. There is no diplopia except on extreme lateral movement of the eyes.

C. Proptosis arising from intracranial lesions excluding subdural hematomas cerebral abscess and cavernous sinus thrombosis, causing unilateral and bilateral exophthalmos from intracranial causes, are usually connected with basal tumors of the anterior and medial cranial fossae. This may be the only symptom for a number of years. In Skydsgaard's[13] series 4% of these patients develop exophthalmos, while Cushing estimates that 8% of all brain tumors produce exophthalmos. Proptosis in meningiomas are most common, especially those involving the pterygoid process, with hypophysial and other intracranial tumors less frequently. Gliomas rarely involve the orbit except those involving the chiasma and optic nerve. Other symptoms which must be looked for are motility disturbances of the 3rd nerve, x-ray changes, variations in visual acuity and fields. Ophthalmoscopic examination may reveal optic atrophy and bilateral stasis.

Patient E.T.: was seen in April 1937, with the chief complaint of feeling that eyes were going to cross for one month and of some blurring of vision. Diplopia occurred on horizontal movement to right. Fundi examination was normal except for moderate arterial hypertensive character of arterioles. In September there was a definite proptosis of the right eye with diplopia. The right fundus showed a two diopter choked disk and several hemorrhages and slight pigmentation of the macula. A paracentral scotoma was present, the peripheral fields normal. Dr. Ernest Sachs using the Naffziger technic, found a meningioma extending back over the cavernous sinus into the middle fossa against the tip of the temporal lobe. The exophthalmos and edema of disk disappeared. After about six months the patient complained of headache and vision loss. About one year following the original operation it was necessary to reoperate on this patient. There had been a regrowth of the meningioma and the greater wing of the sphenoid was removed and all the tumor mass that could be found, but there was a suspicion that the tumor had invaded the cavernous sinus wall. The symptoms disappeared but again returned in six months. Further operation seemed futile. The patient died two years following the time of the first operation. X-rays of the skull revealed destruction of the posterior part of the right orbit involving the optic canal and anterior clinoid process.

Carotid cavernous sinus aneurysm will produce a pulsating exophthalmos. More will be said of these conditions in subsequent paragraphs.

D. Lesions of the orbit and adjacent tissues

1. Vascular lesions
 (a) Hemangioma
 (b) Varicocele
 (c) Arteriovenous aneurysm
2. Pseudotumors
3. Meningioma
4. Neurogenic tumors
 (a) Neurofibroma
 (b) Fibrosarcoma of optic nerve
 (c) Glioma of optic nerve
 (d) Neurolemma
5. Dermoid & epidermoids, orbital cysts
6. Lymphoma, lymphosareoma
7. Fibroma

8. Mixed tumors of laehrymal gland

The vaseular tumors are slow growing and painless. There is usually very little to be felt in the orbit. Varieoeeles produe intermittent exophthalmos when orbital venous stasis occurs as with the head lowered, rcturning to normal after the head is brought into an upright position. There may be a sensation of pressure in the eye, vertigo and vomiting, but little or no pain. Injection of sclerosing agents has been sponsored by Herbert,[14] Reese[15] and Weekers.[16] Ellett[17] thinks this is a dangerous procedure in eavernous hemangioma. Hemangioma has also responded well to irradiation and excision if encapsulated.

Pulsating exophthalmos is produeed by aretriovenous aneurysm. It is most frequently found in eavernous sinus type in whieh there is an abnormal eommunieation between the cavernous sinus and the earotid artery which lies within it. It can oeeur in vaseular tumors of the orbit such as cavernous angioma, malignant hemangioendothelioma, or arteriovenous aneurysm of the ophthalmie vessels within or just outside the orbit. There is usually a bruit present. Ocular muscle weakness associated with exophthalmos due to pressure on the third and sixth nerve occurs in the aneurysm of the eavernous sinus. Diplopia and visual field disturbanees may be present. The pupil may be dilated and the optie disk hyperemic. Optic atrophy has been noted where the pressure has been prolonged. Birge[18] states that oxygen studies from the internal jugular vein shows an abnormally high oxygen saturation in arteriovenous aneurysm. Compression of the carotid will reduce the pulsation, bruit and proptosis. The treatment is exeision of the aneurysm or ligation of the internal or common earotid.

Those eases of proptosis due to ehronic inflammatory reactions in the extra-ocular museles and the periorbital tissues have been classified under the heading of pseudotumors, Reece,[15] Dunnington.[19] The etiology has been attributed to foei of infection by eontinuity or metastasis, tubereulosis, syphilis, trauma and unknown origin. In eontrast to primary tumors, the pseudotumors oeeur mueh later in life, the exophthalmos develops mueh faster and there are no abnormal x-ray findings. Edema of the eonjunctiva and lids is a frequent finding and may progress to a malignant exophthalmos previously discussed. There is a tendency for the proptosis to regress spontaneously, although some may remain permanently. Absolute diagnosis eannot be made without an exploratory operation and biopsy.

Meningiomas may occur around the optie nerve within the orbit itself. Primary tumors of the optie nerve include neurofibroma, neurolemma, fibrosarcoma and glioma. Neurofibroma oeeurs most frequently. There is a gradual unilateral loss of vision followed by proptosis and increase in the size of the optic foramen with visual field disturbanee. The tumor may involve only the intra-orbital or intraeranial portion of the nerve. There may be defects in adjaeent bone and evidence of tumors elsewhere in von Reeklinghausen's disease. If the tumor is localized within the orbit, surgieal removal gives a good prognosis and local recurrences are rare. Final diagnosis rests with the microseopic study.

Gliomas are rare in eomparison to other optie tumors and usually develop in the eranial eavity first and early in life.

Dermoids, epidermoids and orbital eysts usually do not produce exophthalmos unless they invade deep and posterior to the globe. They are slow growing and ean produee destruetion of bone and fat by pressure necrosis. These well encapsulated growths respond well to surgieal removal.

Mixed tumors of the laehrymal gland, though benign, must be eonsidered malignant because they tend to invade adjaeent structures and are apt to recur after excision.

Sarcoma of the orbit occurs in young persons and is highly malignant and rapid growing. The prognosis is poor in spite of irradiation and radical surgieal intervention.

Lymphosarcoma usually produees a bilateral exophthalmos. It responds well to x-ray therapy. Aeeording to most authorities this is only one manifestation of a fatal systemie disease and therefore has a poor prognosis. The one case I have had whieh showed no other evidence of lymphsarcoma except bilateral proptosis, responded beautifully to x-ray therapy. Two years have elapsed and to date there has been no recurrenee.

The diagnosis of the causative factors for

exophthalmos frequently requires a painstaking investigation, requiring the cooperation of the other specialties. The importance of x-rays, particularly of the optic foramen, skull and sinuses, blood studies, general physical examinations, ocular muscle examination and fundi studies, cannot be over-emphasized. Above all, exploratory operative procedure for biopsy study should be made before radical surgery of the orbit is considered. This is especially true since pseudotumors and malignancies in many cases must rest upon tissue examination.

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DISCUSSION

Dr. Hallard Beard, Chicago: The exophthalmos which develops in association with toxic disease of the thyroid is one of its most distressing and baffling complications. Most of us have had the experience of promising a patient so afflicted an amelioration, or at least an arrest in the progress of an exophthalmos, if he would have a surgical operation on the thyroid gland, only to see it grow worse after the thyroidectomy. If such cases be due to a disordered secretion of the anterior pituitary, rather than of the thyroid, one might expect more satisfactory results from irradiation of the hypophysis than have been forthcoming.

The evolution of our theories as to precisely the causative mechanism in this type of exophthalmos is interesting and is probably still far from complete. After we had been obliged to discard the notion that contraction of such puny muscles as the orbitalis, or Landstroem's muscle could be responsible, came the conviction that proptosis resulted solely from an actual increase in volume of orbital contents. New tissue was thought to be deposited, notably fat, and vascular channels increased in number and capacity. Latterly, the increase in volume of orbital structures has been attributed more to a gradual influx of fluid — a simple and persistent edema — and, in part at least, to a very considerable thickening of the external ocular muscles. This latter change appears to be in the nature of a fibrous hypertrophy or pseudo-hypertrophy. Cases have been cited in which, upon autopsy, the area of cross section of the ocular was found to be increased as much as eight times the normal.

The great discomfort of the patient, and the apparent imminence of destructive effects on the corneae have often induced the physician to be rather precipitate in adopting drastic measures of treatment. It must be borne in mind that retrogression eventually takes place in not a few cases of even severe thyrotoxic exophthalmos, and that if one can, by patient and painstaking care, avoid ulceration of the cornea until regression occurs, he may yet save the eyesight without resort to such radical procedures as, say, the Naffziger operation. I refer to devices designed to conserve the moisture, or prevent drying of the cornea by day and by night. Spectacles or goggles, with airtight protective shields built up about them of some of the newer plastics, can be worn during waking hours with much benefit, and effective measures have been devised to prevent exsiccation during sleep.

I am much impressed by Dr. Thacker's comprehensive presentation of this whole subject, and by his frankness in describing the typically illustrative cases. It would be well for us to digest thoroughly his remarks on the localization of orbital tumors, judging from the character of the displacement of the eye itself.

I should like to ask Dr. Thacker if he has not found unilateral proptosis due to ethmoiditis a condition rather frequently encountered among young children; and if it does not show a tendency to spontaneous regression if left undisturbed.

Dr. Edgar A. Thacker, Urbana, (closing): In answer to Dr. Beard's question, my procedure, when the ethmoid has broken through into the orbit, is to wait until localization has occurred, if there is any, and then make a simple incision and drainage. I did not mention the acute conditions, since I left that out because we are taking up conditions harder to diagnose. Ethmoiditis is a common condition; breaking

through the orbit is common in children as compared to adults, because that plate is thin in children and in these conditions the other sinuses are not developed much. So simple drainage is the best procedure, with infraction of the middle turbinate and stimulation of drainage intranasally. I recently did simple drainage in a child five years old, who also had an antrum infection. He came down with osteomyelitis a few weeks later, was operated on, and fully recovered.

I wish to thank Dr. Beard for his discussion of this paper.

EMOTIONAL CONTROL A FACTOR IN PRESERVING THE INTEGRITY OF THE HEART

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In addition to marvelous and life-saving drugs, proper diet and surgical treatment of heart disease, or more properly cardiovascular disease, there are three other therapeutic measures of vast importance. They are not new. Their value has long been known to the medical profession. The technique of the administration of these remedies is difficult to master and the resistance of patients to taking them is often almost impossible to overcome. If these remedies could be dispensed from a bottle in teaspoonful doses, according to the doctor's directions and the patient's needs, people suffering from cardiovascular disease would lead longer, more comfortable and more useful lives.

These three therapeutic measures have the protective value of vaccines and the curative qualities of serums. As a preventive of cardiovascular disease and as a remedy when damage has occurred, there are no drugs to take their place. Omitted, there is no drug that will give more than temporary relief. These three well known remedies are emotional control, rest and exercise. Unless the patient afflicted with heart disease can be taught to acquire emotional control, the other two measures will be largely inoperative. Physicians will learn that study of the life of man and consideration of the bombardments his nervous system endured and continues to endure, both genetically and individually, will add greatly to their ability to administer the psychological teachings needed by patients who are victims of heart disease.

Emotional Control. — The sources from which a knowledge of emotional control can be obtained are parental teaching; observation of humans and animals who are instinctively calm; study of the history of the races; study of the religions of the world; fiction and philosophical writings.

Relatively few people are, or will be interested in embarking on so formidable a course of study. Relatively few people have the education necessary to understand the meaning of what is presented in this extensive course. Equipped with a knowledge based on scientific methods of inquiry, physicians are the logical dispensers of this knowledge to their patients. Diagnostic knowledge makes it possible for physicians to distinguish between the effects of emotional stress and tissue injury. The course is open to all physicians and can be studied in their leisure moments. Some day the premedical course will include a synopsis of the subject of emotional control, sufficient to enable the graduate in medicine to prosecute further research under his own power. Since the dawn of medicine, physicians have known of the damage done to the physical welfare of the patient by the ravages of emotional instability, but it is not so long ago that this knowledge was established on a scientific foundation. Knowledge gained from study of the sources of emotional control will acquaint the physician with the administration of an important remedy for cardiovascular damage, and that other emotional disease, duodenal and gastric ulcer, which curtails the activities and shortens the lives of so many people, including physicians.

The background for teaching emotional control is a general knowledge of the history of man and a special knowledge of man's history as it relates to trauma to the nervous system and to the endocrine organs. A medical school education is not sufficient to furnish this background. These incidents of trauma, both physical and mental, beginning early in man's appearance on earth and exercising from that time an influence on the body cells, have been and continue to be kept active by teachings and beliefs, the truth of which the majority of people in succeeding generations have been and are loathe to question. Because of this tendency to cling to old concepts, progress in the development of scientific inquiries in all branches of learning was, for many centuries, sternly suppressed. The undaunted few, the world's first scientists, who persisted in their researches were

persecuted, tortured and sometimes put to death. Those persecutions contributed an hereditary influence of far-reaching proportions.

In considering the subject of emotional control, we are at once reminded of two primitive and protective instincts, the possession of which are necessary to the protection of the life of the animal in the wild state. These primitive and protective instincts were of equal importance in protecting the life of aboriginal man; but they also exercise a devastating influence on the character of the metabolic processes and the stability of the emotions. These two primitive and protective instincts are fear and anger.

Fear may be an incentive either to alertness or enfeeblement; anger prepares the animal either for flight or combat. Exercise of these emotions protects the animal from dangers from without, but at the same time summons detrimental forces from within that eventually may cause death. Physiologists have submitted indisputable evidence of the toxic effect produced by fear and anger upon the cardiovascular and other systems of the body, especially the gastrointestinal.

When man learned to protect himself from physical attacks by lower animals and his predatory fellowmen, he proceeded to invent hobgoblins that could be used to frighten and control other men. Man shares with the lower animals the desire to inspire fear and anger in the minds of his fellows. As evidence of this desire, the human race revels in the contemplation of opposites. This predilection provides the stage for a constant play on the emotions. A few of the opposites that challenge universal interest are —

God and the Devil
Heaven and Hell
Good and Evil
Conservative and Radical
Beauty and Ugliness

Man more or less eagerly seeks to attain the positives in this category and with less zeal attempts to abhor and evade the negatives. In neither effort is he very successful. In his struggle to uphold virtue and right he is hampered by two obstacles, the pull to the left and the law of mutation.

From time immemorial two conflicting philosophies have struggled for supremacy in the guidance of human emotions. The objective of one of these philosophies is to perpetuate the instincts of fear and anger. Its chief ally is ignorance. The other philosophy diligently, but not with the same emotional enthusiasm, endeavors to allay those instincts. Its chief ally is enlightenment. These two philosophies were recognized early in man's existence. The pagan world believed the warring gods of the heavens vented the wrath of their frustrations on puny and defenseless earth dwellers. The pagans worshipped and feared the warring and cruel gods. They also worshipped and loved the gods and goddesses whom they believed interceded and protected them from the wrath of the cruel gods. To honor the virgin goddess Athena, the Greeks built on the Acropolis the beautiful Parthenon. They were striving for the establishment of the brotherhood of man. In our struggle for improved and better ethical standards and the goal of the brotherhood of man, we are doing much the same thing. We build tombs for unknown soldiers. We erect modest churches and ornate cathedrals where we go to listen to ancient truths retold and to restore our souls. Our most faithful patients, without deserting us, turn to the Psalms and the Sermon on the Mount for consolation and hope. The sweet singer of the Old Testament and the philosopher from Nazareth continue as the outstanding psychologists whom scientific progress has not desired nor tried to supplant.

With the passing of centuries, old threats, old superstitions, and old tyrannies slowly lose ground. Understanding supplants groping and ability to reason correctly replaces vain conjecture. Experience and breadth of knowledge show the futility of indulging the instincts of fear and anger and the superior value of exercising calm judgment. Progress in the extent of individual thinking, makes easier the task of the physician to teach his patients emotional control.

In the domesticated animal, the instincts of fear and anger are greatly modified but never abolished. Neither has man been able to free his mind from the ravages of these two destructive forces. Fear is one of the most deeply rooted instincts possessed by the animal population, man included. It is not likely that man will ever free himself from its influence. Free-

dom from all variety of fears would very likely lead to man's undoing, and the end of the human race. Education and progress, bringing increased knowledge and understanding of things that were profound mysteries to men and women of only a few centuries ago, have released the human race from the bondage of many disturbing inhibitions but have not banished the instincts of fear and anger. There are two general types of fear, one that may very properly be termed legitimate, the other, deplorable. Of especial value to the existence, happiness and prosperity of the human race are those fears that fall within the category of caution. A few examples and their remedies are —

Epidemics — Public Health Measures

Wars — Fair Dealing

Quarrels — Closed Mouths

A few deplorable fears and their remedies —

Fear of the unknown — Investigation

Fear of individuals — Normal amount of egotism

Fear of thunder and lightning — Common sense

Fear of chronic fatal diseases — Education and assurance, based on careful examination, by physicians.

Those unfortunate individuals who begin their business or professional careers believing life's journey should be travelled in high gear, up hill, down hill, and on the level stretches, discover when they reach the fourth decade, "Much haste, less speed." To their great surprise, old age has overtaken them and the fifth decade all too often sees their liquidation. John Hunter, the famous English surgeon, was an illustrious example of this type of individual. At forty-five, Hunter had a coronary occlusion, with symptoms predominantly abdominal. A detailed description of the attack was published by Everard Home, his brother-in-law and surgical assistant. Following recovery from the attack, Hunter continued his work in a somewhat lessened tempo for twenty years. After a stormy session with the Board of Directors of St. George's Hospital, Doctor Hunter dropped dead of a coronary occlusion. For some time prior to his death, he had told his associates of the effect on his heart of emotional stress and expressed the opinion that a major emotional episode would prove fatal. Doctor Hunter died in 1795. The following year Doctor Home published two small volumes containing the medical and surgical contributions of Doctor Hunter. Included, was the description of the attack of coronary occlusion he suffered at forty-five and the autopsy report of the repetition at the time of his death at sixty-five. These ante- and post-mortem reports were ignored by the medical profession and it remained for Doctor Herrick, one hundred and thirty-seven years later, to reestablish the clinical diagnosis of coronary occlusion as the cause of the sudden death of apparently healthy men and women.

The common laborer is probably the least frequent victim of coronary disease. Daily muscular activity helps keep the blood and lymph streams free from stagnation. Detachment from anxiety that goes with physical exertion leads to active digestive processes and freedom from worry. Fatigue at the end of his working day is one of the best sedatives to insure eight hours of restful sleep. The laborer's wants are few, his amusements simple, and his anxieties largely non-existent. Heavy responsibilities are beyond his mental acumen and of all people he is most content to proceed "Along the even tenor of his way." Study of the health history of the laborer, man or woman, will prove one of the best text books on the therapy of the heart in health and in disease.

One of the obstacles encountered by the physician in his attempt to teach emotional control is the ancient and persistent companion of man, known as worry. The physician should acquaint his patients with the fact that worry is a condiment to be taken in small amounts like red pepper and garlic. A little worry, like a little leaven, acts as a stimulant, helping human beings to be independent and self-sustaining. If this is understood, worry will cease to be a burden by day and a disturber of sleep at night. Instead, it will become a harbinger of prosperity and happiness rather than a destroyer of composure.

When the average successful business or professional man acquires a certain financial competence, his program of living changes. He is not burdened with details that formerly kept him busy. He has more money. Time hangs heavily on his hands and he turns to golf or social activities, either of which may be too strenuous

for his age and established habits of life. Happy is the man who chooses a hobby early in life and rides it with enthusiasm tempered by logical restraint. Helpless is the man who reaches the age when the strenuous activities of business or profession are too much of a strain and he finds himself with nothing to do but eat and sleep. It is not easy at that time of life to acquire and learn to follow a useful hobby. When old men without a hobby retire, their life expectancy is about two years. Their lives lack the incentives necessary to the proper functioning of metabolic processes. Old women live longer. All women have hobbies, either manual or intellectual, acquired in childhood.

If we consider the lives of those men and women who attain great age without cardiovascular accidents, we will find that for the most part they practice a high degree of emotional control. They do not permit themselves to be stampeded by people or circumstances. Usually, they are early risers. Early rising has several advantages, among which are time for a morning bath and shower, time to eat a leisurely breakfast, no hurrying for the morning train and the contented feeling of being on time. The day's meals are better spaced and a more orderly business program is easier to follow. Patients who can be induced to follow this routine will discover they are enjoying greater peace of mind, are worrying less, are not so easily upset and will derive much satisfaction from the emotional control they develop. They will learn that rushing through life may bring certain rewards of questionable value at the sacrifice of health and happiness that may encourage an early exitus.

Rest. — Rest is a therapeutic agent which those patients who, for twenty years or more, have been driving full speed ahead, will usually refuse to take. If they grudgingly agree to observe some of the rules prescribed by the physician, they do it with so much resentment and lack of belief in its necessity, that little or no benefit accrues to their nervous systems. Rest, to be beneficial, must be enjoyed. These patients find it most difficult to understand how rest could or should be enjoyed by any ambitious person. They do not appreciate the early warnings given by their failing hearts and regard the symptoms as temporary feelings of discomfort to be dispelled by increased efforts. Their physicians, harassed by their obstinacy, are inclined to cease trying to teach them.

In the early stages of decompensation, rest may be all that is required to restore the overdriven heart, but education of the patient by the physician, which means psychogenic therapy, and the employment of appropriate drugs, are usually necessary. Regardless of the degree of intelligence possessed by the patient, he is hopelessly ignorant of the things to be done to restore and preserve the integrity of the failing heart. Passive congestion of the lungs is one of the first signs of trouble. This is followed by engorgement of the abdominal viscera and other tissues. The temptation to employ digitalis to relieve the edema and increase the force of the heart beat is strong, but that is not the best way. Rest and depletion of the engorged organs will avoid the necessity of increasing the force of the heart beat by the use of digitalis. Coramine, which is a vasodilator and a respiratory stimulant, is the more logical drug. The traditional belief held by patients that vigorous catharsis is dangerous to their welfare is difficult to combat. Depending upon the degree of decompensation, the rest period may have to be continued for three or four months, or longer.

Rest as part of the treatment of children who are victims of cardiovascular disease, is a simpler problem. Like the lower animals, the child when put to bed and provided with toys and books, if let alone, follows his instincts and will not exercise beyond the threshold of his endurance. If treated at home, the family should be warned against trying to entertain him. He may rebel the first few days at the curtailment of his activities, but will reconcile himself and be content to remain in bed for weeks. As recovery progresses, the child will become more active. Neither encourage nor restrain him. In the course of his convalescence he may wear out the spring and mattress.

Exercise. — Exercise is a subject of absorbing interest to all children and to a lesser extent to all adults. Exercise has a physiological and psychological value to the participant, the community and the nation. Julius Caesar noted the moral and physical degeneration of his armies after a winter of idleness in Rome.

For the healthy adult there is no exercise that equals the exercise of making a living. People who follow a sedentary occupation should walk a minimum of three miles a day. One-third of the distance in the morning, one-third at noon and one-third in the evening.

The amount of exercise for the cardiac patient is to be determined by his physician. The supervision should continue from the period of his convalesence to the time when, without being reminded, the patient shall have learned to live within the threshold of his endurance.

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THE RORSCHACH TEST IN POST-ENCEPHALITIS

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A recognition and application of the psychological factor in somatic disease has long been used by the general practitioner in what he calls his "bedside manner". A more thorough and systematic application of this principle has been left to the psychiatrist. He has come to use it as part of his treatment of the patient in terms of the total pattern of the physiological, psychological, and social factors involved. In the treatment of such disorders as paresis and chronic alcoholism, there is a strong somatic component, but the psychological factors must also be considered in the total treatment of the disorder.

Evidence is accumulating that suggests that a total treatment of post-encephalitic conditions must include a consideration of psychological factors. This is in no sense meant to imply that the disorder is not primarily somatogenic in nature. Most of this work has been developed by Dr. Smith Ely Jelliffe in a series of papers[3], [4], [5], [6].

His thesis, as developed in one of his most recent papers[6], can be somewhat paraphrased as follows: The importance of all the physiological factors is not denied but if one is to understand the motor picture, he must understand the unconcious factors which influence the motor system. The post-encephalitic patient has two threats — a real one caused by the discase and a neurotic one caused by a reactivation of old impulses and conflicts which break out of repression because of damage to the nervous system. This results in a "condition of tension" or a "tone of the motor system" which is a complex of affective attitudes. Schaltenbrand[11] was of the opinion that the tremor which results is the same as that which we observe in anxiety and rage. It is the unconscious factors which bring about the ambivalent postures of recoil and challenge, of attack and retreat. The tremor then, is a reflection of the "condition of tension", "inner posture" or "tone of the motor system" as dominated by reactions to the unconcious hostile impulses in a dammed-back condition. More characteristic though is the bent posture of "defense", which is comparable to the attitudes of defense of antique and modern statues. The tremor, then, represents anxiety and hostility while the bent posture reflects an opposite, ambivalent attitude of defense.

The purpose of this paper is two-fold. First of all, to compare the findings of this study with those of other studies so as to more clearly determine the characteristic Rorschach pattern for post-encephalitic conditions. The second aim is, through the medium of the Rorschach test, to study the several personality factors as developed by Dr. Jelliffe.

Rorschach[10] reports a study of one case of Encephalitis Lethargica which was made during the acute period of the infection. Subsequent studies by others[1], [2], [14] made in 1927, 1938 and 1939, but not available to the author, were made sometime after the acute period of infection.

According to Klopfer and Kelly[7] , Rorschach studies on post-encephalitic conditions reveal poor form — usually between fifty and seventy percent, perseveration, confabulation, predominance of color responses, oligophrenic detail responses, disturbed succession, variation between tests, and the possibility of a large number of human movement responses. In addition to this, psychoneurotic manifestations are often present, particularly the phenomena called color or neurotic shock. This suggests the presence of a strong anxiety process as an integral part of the total personality make-up.

A study made by Karen Alper[12], [13] in 1942 on nine post-encephalitic cases showed, first of all, little drive although the number of responses is not constricted. This is reflected by many over-simplified and undifferentiated whole re-

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sponses. This is a sign of the lack of capacity for discrimination and analysis: it represents a dependent adjustment to an easy, facile environment. This same trend was also reflected in the narrow range of interests and content of the responses. Psychoneurotic reactions were manifested by neurotic shock, considerable anxiety, depressive feelings and sexual shock. They differ from psychoneurotics in that there is no compensation reaction such as a retreat to unusual details or white space responses. On the other hand, none of the impotence, delayed reaction time, or sense of frustration of the so-called "organic" patient was present. There was no struggle with impulses, indicating hostility toward people.

The present experimental group is composed of eight men and six women — fourteen cases in all. Five of the patients were typical cases of post-encephalitic parkinsonism; the other nine showed a few of the symptoms usually associated with the syndrome. Five of the cases showed no tremor at all: four had oculargyric crises; and one was a post-encephalitic behavior problem. One of the big drawbacks of a study of this type is the small number of cases usually available. Several cases had to be eliminated because of deterioration or inability to cooperate.

The pattern of responses of this group of post-encephalitis cases on the Rorschach test is distinguished primarily by poor interpretation of form — usually the form percentage is lower than seventy to seventy-five per cent, a predominence of color responses over movement responses, the color responses are of the bright color variety, neurotic shock is very frequently present, the succession of responses is disturbed, the mode of apperception is disturbed to the extent that there is a predominence of either whole or small detail responses, the organization score is low.

Secondary factors which are sometimes present include perseveration, confabulation, more than twenty responses, narrow content and feelings of depression. These findings agree substantially with the previous studies mentioned; there are some exceptions.

The most outstanding findings were the presence of neurotic shock* and the quality and quantity of color responses. Neurotic shock is a phenomena by which the perception of the colored blots produces a state of anxiety in the patient that is evidenced by such reactions as a delay in reaction time, remarks and exclamations indicating tension and anxiety, a decline in the quality of form perception, etc. The number of movement and color responses tends to be restricted but the number of color responses is in nearly all cases greater. In addition, these were mostly of the bright color (C and CF) variety; thus, on one hand we have a well-defined anxiety process present, coupled with an affectivity that is impulsive, labile, and aggressive in nature. Hostility and aggression, in addition, were reflected in such responses as: "two boys with their heads cut off", "a woman — she lost her head", "two bodies stuck together". One male patient referred to the penis as "a man's irritation".

These findings corroberate Jelliffe's statement concerning the presence of hostility and a "state of tension". Often, when responding to the blots, and especially on the color blots, the tension and tremor would become so severe that it was very difficult to make responses. For one patient, the tension, emotional excitement, anxiety and severity of the tremor, on the colored cards especially, became so great that the test had to be discontinued. Along with this picture resembling a psychoneurosis, there are often responses indicating the presence of unrestrained impulses coupled with feelings of depression and guilt.

The low form percentage and disturbed succession of the responses coupled with the frequent presence of perseveration and confabulation show a severe disturbance to the thought processes and contact with reality which is probably brought about by the neurological damage, the anxiety process, or both. The poor mode of apperception with a large number of poorly structured wholes or a pre-occupation with small details is further evidence of this intellectual disturbance. This shows a poor capacity for discrimination, analysis, and creative thinking. This intellectual poverty is also shown by the narrow content in a total number of responses that is not too constricted. Only three of the patients showed a sufficient number of Piotrowski's[9] ten signs for so called "organic" patients.

Summarizing: These findings are in fairly

*For a more adequate discussion of neurotic shock than can be given here, see Miale and Harrower-Erickson.[8]

good agreement with previous studies. The anxiety or "condition or tension" and the aggresion and hostility, as mentioned by Jelliffe, are present. There is also present poor intellectual control which indicates poor contact with reality or a deterioration process. This may result from the neurological damage, the anxiety and tension present, or both.

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GUILTY

The prisoner was on trial for stealing ducks. His counsel addressed the jury at length, pointing out that it had not been proved conclusively that the prosecutor had lost any ducks; that the ducks found in the prisoner's cottage were not those of the prosecutor; that the prisoner had established an absolute alibi.

Just as the judge began to sum-up, the prisoner interposed and asked if he might say something. As an indulgence, this was permitted.

"All I want to say, gentlemen," he remarked, "is that I wish I'd never seen those birds."

HEMORRHAGIC ENCEPHALOPATHY FOLLOWING FIVE DAY TREATMENT OF EARLY SYPHILIS WITH MASSIVE DOSES OF MAPHARSEN: (REPORT OF A CASE WITH RECOVERY).

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With the introduction of the massive dose treatment for early syphilis, Ehrlich's concept of a "sterilisatio magna" appeared to be on the threshold of approximate realization. Serious complications and fatalities occuring in consequence of the treatment proved, however, disconcertingly high. Thus, the incidence of cerebral involvement, which constituted almost one-half of the various death causes[1,2], was 1.8%[3] in contrast to 0.015% in cases routinely treated[2]. The mortality rate under routine therapy was less than one-seventh that of massive dose therapy[4] and only one-fourth of the patients who developed hemorrhagic encephalopathy escaped death[2].

The introduction of mapharsen both for routine and five-day treatment brought a very definite amelioration of the problem. Elliott and co-workers[4] reported only 0.25% fatalities in 2,000 cases, and Leifer and associates[3] saw the occurrence of hemorrhagic encephalopathy drop to 1.1%.

A further source of encouragement lay in the fact that the mortality rate among cases with hemorrhagic encephalopathy had also appreciably receded. From a total of twenty-four cases compiled from the literature, six, or 25% were fatal, whereas seventeen, or 75% recovered, (Table 1), a percentage in almost precise opposition to the mortality rate of 76% obtained from a survey of hemorrhagic encephalopathy following the administration of other arsenicals embracing a twenty-eight year period[2].

The following case report of a fifteen year old girl who recovered from a typical hemorrhagic encephalopathy after a course of five-day treatment with mapharsen confirms the relative benignance of that complication following the in-

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TABLE 1

Author	Number of Hemorrhagic Encephalopathies	Number of Fatalities	Number of Recoveries
Bowman (23)	2	0	2
Boyd (13)	2	0	2
Elliott (4)	2	2	0
Hahn (5)	2	1	1
Leifer (3)	1	0	1
Levin (24)	1	0	1
Rattner (25)	2	0	2
Schock and Alexander (26)	3	1	2
Thomas (13)	8	2	6
Usher (27)	1	0	1
Total	24	6	18

travenous use of mapharsen. The case may, moreover, prove interesting from a therapeutic standpoint and serve as a contribution to the etiologic problem of the development of cerebral complications in a given individual.

E. R., an adolescent white female, fifteen years of age, was admitted to the Chicago State Hospital, May 4, 1943, as a special guest for five days intensive arsenical therapy on the recommendation of the Department of Public Health. The patient gave a history of a skin rash and sore throat in early April of that year. A blood test taken on April 23d had revealed four plus blood serology. The occurrence of the primary syphilitic infection could not be accurately elicited but had probably taken place within six months prior to admission.

Physical examination on admission disclosed a generalized papulomacular skin rash distributed over face, trunk and extremities. The mucous membranes of the oral cavity showed whitish mucous patches with predilection for the peritonsillar areas. Condylomata lata were observed on the major and minor labia; a profuse sero-sanguineous discharge flowed from the vaginal canal. There was no gonorrhoic infection. The lymph glands of the inguinal region were moderately enlarged and tender. Heart and lungs were found essentially negative. Blood pressure was 120/70 mm. mercury; pulse 80/sec. The abdomen was soft and there were no pathologic masses palpable. Neurologic examination revealed no pathologic findings. Although the patient, as stated, had been received as a guest expressly for the treatment of the venereal condition, a brief mental examination was performed. Besides a history of detention for petty delinquencies, wayward sexual trends were disclosed. No psychotic manifestations were apparent.

The urine analysis showed specific gravity of 1.002, acid reaction, negative sugar tests, trace of albumen and 3-5 leucocytes per high power field. The blood picture disclosed 4,840,000 erythrocytes and 12,200 white cells. The hemoglobin was 14.5 gm. The differential blood count showed a shift to the left, but no pathologic cells.

Based upon a diagnosis of early secondary syphilis, the five day intensive antiluetic therapy with mapharsen was instituted May 12, 1943.

A total of 1.2 gm. of mapharsen was given by continuous drip method over a five day period. The patient tolerated the treatment very well with the exception of the usual mild complications arising from occasional headaches and emesis. The body temperature during treatment fluctuated between 98.6° and 99.6° F. Daily urine analysis had shown no essential changes. The white count had receded from the original 12,200 to a low mark of 6,000 on the third day, rising again to 8,300 on the fifth day.

On the first day following termination of treatment, May 17, 1943, patient complained of weakness in her lower extremities. On the 18th of May, she developed numerous urticariform skin lesions on trunk and extremities varying from one-half inch to four inches in diameter. Calcium gluconate, 20 grs., t.i.d., daily by mouth given for three consecutive days failed to alleviate the skin condition. The patches increased in size, spreading to the face on the following day. On that day, May 19, 1943, that is, the third day following the completion of therapy, patient commenced to complain of back pains, in addition to the aforementioned weakness of her lower extremities, and showed urinary incontinence. Temperature had risen to 101°; pulse was 120/sec. No focal signs accountable for the elevated temperature were found.

On the evening of May 20th, the rash was fading but ankles and feet appeared moderately edematous. Patient was extremely nervous and required 3 grs. of sodium amytal to find sleep. On the morning of the 21st, patient refused breakfast, appeared extremely restless, and talked incoherently. At noon patient complained of severe pain in the right side of her neck. Restlessness increased nothwithstanding sedation and in the evening patient failed to respond to questioning. She continued, brokenly, to be noisy and restless. The temperature had risen to 104.4 rectally and the pulse rate was 120. The respiration was 18. Hypodermoclysis with 5% glucose in saline was then undertaken. The patient became increasingly stuporous, being almost comatose by 2:00 A.M. of the 22nd. Her pupils were markedly dilated, the eyeballs presenting a fixed stare.

On the morning of the 22nd, at 8:00 A.M., patient presented the following picture: She was in an unconscious state, tossing in bed, moaning constantly. She did not respond to external stimuli. The pupils were 5 mm. in diameter and did not react to light. Fundi and discs were negative. Corneal reflexes were present. The neck was extremely rigid. The Brudzinski sign was markedly positive. The big toe of both feet dorsiflexed when the extended leg was flexed at the hip joint, (Edelmann's great toe phenomenon).

The deep tendon reflexes were absent with the exception of the right biceps. Urinary and rectal incontinence were manifested. Temperature was 101.8°; pulse rate, 120; respiration, twenty-eight per minute. The spinal fluid findings were as follows: Normal pressure; 28 lymphocytes; 4 neutrophiles; negative Ross Jones, trace of Pandy; negative benzedine test. 77.5 mg% sugar. Negative Kahn; Lange curve: 1111100000.

Intravenous infusion of 400 cc of 25% sucrose, followed by 1000 cc of 10% glucose in saline was given. Later that day, 2,000 cc of 5% glucose were given by hypodermoclysis. In the afternoon, the temperature rose to 104.6°, with the patient appearing to be in a terminal condition.

In the late evening, 500 mg. sodium thiosulfate and 1,000 mg. of ascorbic acid were injected. At 5:00 A.M. on the 23d of May, the patient had myoclonic movements of her upper extremities. The temperature at 6:00 A.M. read 102° in recto. At 8:00 A.M. her left big toe was in constant dorsiflexion. There was a slight drooping of the left corner of the mouth. Aimless movements of the right arm were present. Otherwise, the status had remained unchanged.

She again received 500 mg. of sodium thiosulfate and 500 mg. of ascorbic acid intravenously and 2,000 cc of 5% glucose in saline subcutaneously. In addition, 10 mg. of thiamine chloride and 100 mg. of nicotinic acid were given.

At 1:30 P.M. of the same day, the patient's condition had somewhat improved. Temperature was 101.6°. The restlessness had yielded to a sound sleep from which she responded sluggishly to pain and noise stimuli. She followed moving objects slowly. The purposeless movements of her right arm were not so pronounced and she appeared to be resting more comfortably.

The pupils measured 5 mm. in diameter and were disrounded, especially the right. Pupils reacted promptly to light and accommodation. Fundi and discs continued to show a normal appearance. The neck remained extremely rigid with the Brudzinski sign still markedly positive. Edelmann's big toe phenomenon likewise remained positive, particularly on the left side. The deep tendon reflexes were absent with the exception of the right biceps, which was weakly present. Sodium thiosulfate and ascorbic acid injections were repeated in the amount and mode mentioned above.

At 3:30 P.M. patient was able to take small sips of water given by dropper. At 5:00 P.M. she again received 500 mg. of ascorbic acid intravenously. At 6:00 P.M. the temperature was 100° rectally; the pulse 100 per minute.

At 9:15 P.M. the patient vomited small amounts of clear liquid with small particles of mucous. Temperature had fallen to 99.8°. Despite the emesis, she was permitted to continue to sip water from a medicine dropper.

During the night, patient slept well at intervals; however, she refused to take liquids by mouth. The movements of her eyeballs appeared more nearly normal and at 2:30 A.M. of the 24th she feebly but correctly responded to questions pertaining to the identification of her relatives. Her head was held in right-left rotation; she was still incontinent in urine and feces.

At 9:00 A.M. of the 24th, temperature was 97.8°; the pulse, 88. The patient's condition appeared much improved. Her eyes followed moving objects with rapidity. The head remained strongly rotated to the left, however, and extreme resistance was offered upon attempts to move it to the midline. She followed simple commands, such as, "Squeeze my hand," "Touch your chin," etc. Brudzinski was still present. The deep tendon and periosteal reflexes had now returned.

After intravenous administration of 500 mg. of ascorbic acid, she received 2,000 cc of fluids subcutaneously. At 2:00 P.M. she received 10 mg. of thiamine chloride and at 4:00 P.M. another 500 mg. of ascorbic acid intravenously. 125 cc of eggnog by stomach tube were retained. In the evening she summoned the nurse and at midnight asked for food and a pillow. The neck rigidity had diminished. The patient turned her head slowly from side to side. In the early morning hours of the 25th, the patient became restless, moaning and crying, and complained of abdominal pain. She drank milk slowly from a glass and recognized her parents. At 9:00 A.M. the temperature was 99°; pulse 88. She was given 500 mg. of ascorbic acid, 10 mg. of thiamine chloride and 50 mg. of nicotinic acid. She offered lucid responses to questions. The neck exhibited only mild rigidity; the Brudzinski was weakly positive.

At noon, patient consumed a good meal and took a total of 800 cc of fluid during the course of the afternoon. There was a persistence of urinary and fecal incontinence. At 5:00 P.M. the morning medication was repeated. Her temperature continued to be normal and she voided voluntarily. At 9:30 patient had become so restless that she required sedatives (hyoscine hydrobromide, gr. 1/100 h.c.). On the morning of the 26th, patient hallucinated freely and was quite restless and confused. Later in the morning, however, she identified objects and persons correctly and was partially oriented. She again received 100 mg. of nicotinic acid and 10 mg. of thiamine chloride intramuscularly twice during the day. She was now continent in urine and feces. Intermittently during the course of the day and night, confused periods and delirious hallucinatory episodes occurred.

On the morning of the 27th, the patient loudly discussed details of her intimate sexual relationships and would shout at the top of her voice. Episodic delirious-hallucinatory experiences continued. She refused breakfast but took lunch. From the early afternoon on she became increasingly lucid and rational and appeared nearly completely recovered on the following day, May 28, 1943. On the 29th she was allowed to sit in a wheel-chair for a few minutes and walk about the bed. The next few days were uneventful. Final neurologic examination immediately prior to patient's discharge

on June 1st was essentially negative with the exception of impaired tandem gait and mild ataxia while standing on one leg with closed eyes.

COMMENT

A brief summary of the case report may stress the following points:

A healthy, robust, fifteen year old girl with early syphilis developed an urticariform erythema on the second, and cerebral complications commensurate with the typical symptoms of a hemorrhagic encephalopathy on the third day following completion of a five-day treatment course with a total of 1.2 gm. of mapharsen. Despite energetic general medical and nursing care the patient reached an almost terminal condition on the second day following the onset of the cerebral symptoms. Fifteen hours following the intravenous administration of a total of 1,000 mg. of sodium thiosulfate, 1,500 mg. of ascorbic acid, 10 mg. thiamine chloride and 100 mg. nicotinic acid, patient had decidedly improved and continued to improve rapidly under daily injections of 1,000 mg. each of ascorbic acid and sodium thiosulfate, including thiamine chloride and nicotinic acid medication, until final recovery had been accomplished nine days after the onset of the cerebral symptoms.

One of the questions of major importance in this case is centered upon the efficacy of the therapeutic agents employed. With the mortality rate of hemorrhagic encephalopathy following five-day mapharsen treatment being only 26%, and with the added consideration that the patient was a physically mature and robust individual, an observer might be inclined to assume that recovery would have ensued in any event under adequate nursing and medical care. This assumption receives further confirmation from investigations[6,7], which proved that "the urinary, fecal or total arsenic excretion was not significantly affected by the administration of sodium thiosulfate in properly used therapeutic doses." The authors "obtained no evidence that sodium thiosulfate injected intravenously mobilizes arsenic from body stores for urinary elimination . . . Sodium thiosulfate does not mobilize and probably does not immoblize arsenic stored in body tissues."

The use of ascorbic acid, however, finds a quite different appraisal in the literature[8]. It had been recently shown that ascorbic acid prevents the formation of the toxic oxidation products in vitro, when added to neoarsphenamine or mapharsen[9,10], and its "protective action afforded the human skin against arsenical therapy" was demonstrated[9]. Ascorbic acid in intravenous daily doses up to 300 mg. was furthermore beneficially employed in the treatment of arsenical dermatitis,[10,11] and its merits to forestall, alleviate and relieve the symptoms of arsenical sensitivity conclusively established[8]. It must be emphasized, however, that the efficacy of ascorbic acid through such antioxidant or antihemorrhagic properties in our case remains on speculative grounds. Our clinical observations merely affirmed that the administration of huge doses of ascorbic acid coincided with the turning point in the patient's critical condition. The anti-hemorrhagic action of ascorbic acid appears to be supported by the report of Kalz and Steeves[12] who observed a reduction of the prothrombin concentration in fifteen patients during five days of massive treatment with arsenicals.

In the absence of authoritative insight into the media of prevention or amelioration of the hemorrhagic lesions, we are in addition confronted by the question why such hemorrhages occur "in some patients and not in others"[13].

The concept of Globus and Ginsberg[1] that the cerebral disturbances are due to a direct effect of the arsenical compound or its fractions on the endothelial lining of the capillaries and that the vascular injury is the essential factor in the various reactions doubtlessly receives clinical and pathological confirmation from any particular case. Such a concept does not, however, afford an answer to the question of affective selection. None of the various theories broached, such as individual idiosyncrasy to the drug; sensitization of the capillaries by preceding doses of the medication and deficient elimination of the drug due to adrenal insufficiency or "metabolic idiosyncrasy"; or toxic concentration of arsenical products furnishes an edaquate explanation for the increased susceptibility. It will, therefore, be not without interest to consider the problem from a somewhat different angle.

Quite aware of our scanty material (this present case and a few substantiating remarks in the literature) it must be cautioned that the following cannot be offered as a theory but merely a

conjecture subject to confirmation or rejection from the observation of future data.

In the present case, the patient, who was of average intelligence, had a history of six arrests for petty delinquency; a tendency, well-defined, toward sexual promiscuity was manifest at the age of thirteen. In the present case, social history disclosed that the patient's parents lived in a slum district, the mother of low mental endowment, the father an alcoholic. Since the patient's childhood, the parents had neglected to provide adequate moral guidance. These various factors pointed to a diagnosis of juvenile psychopathic personality.

The reports in the literature on cases of hemorrhagic encephalopathy are rather uniformly limited to a brief physical description of the patient's condition prior to initiation of treatment. Only a few authors, in a very summary manner, describe psychological data. Thomas and coauthors[14] specify one case marked by emotional instability; another case, as dull and of low intelligence. Boyd and Nie[13] record the history in one of their cases as "essentially without significance except for fainting attacks when he was frightened." Bowman and Sheehan[15] report a similar case of a man who developed a toxic encephalopathy, with "an indefinite history of fainting spells, associated with fear of pain, such as experienced on going to the dentist."

Courville and Marsh[16] describe a young woman with a history of idiopathic grand mal in whom the symptoms of hemorrhagic encephalopathy occurred after the second injection of arsphenamine. Levy[17] has published the case of a physically and mentally well developed thirteen year old girl suffering from congenital syphilis who had always been of a restless disposition. It is very difficult to decide whether or not the authors in reporting cases of hemorrhagic encephalopathy following arsenical medication had reviewed the psychologic status of their cases prior to the cerebral incident or whether the usual remark that the history of the patient did not show any "essential findings" actually was intended to convey the impression of an apparently normal and emotionally stable individual whose life remained uncolored by any nervous or mental deviation. It is also possible that pertinent information was unavailable.

Conferring with a group of writers who had published their observations on massive arsenotherapy in early syphilis, it was learned from Usher[18] that among his case material encephalopathy developed in a "definite psychopathic personality." Rattner[19] comments that the five day routine had to be interrupted in approximately 6% of his patients because complications developed. These patients were described by the internes in terms such as "peculiar personality, untrustworthiness, nuts, and so on." Boyd[20], however, pointed out that he had seen numerous "unstable, unpredictive psychopaths of the prostitute and criminal classes who had gone through massive arsenotherapy without the least difficulty."

Bowman[21] observed epileptiform seizures, grand mal in character in a patient who did not admit until after the treatment was started that she had been suffering from epilepsy. Thomas[22] reports that of eight definite clinical cases of arsenical encephalopathy, one was "an irresponsible type with homosexual tendencies"; another patient "had a very low grade mentality, and who might well be said to have a psychopathic personality"; and a third case, "who was practically a moron."

In the light of these merely suggestive data, it may be but tentatively surmised therefore that an individual known to be afflicted with signs of an organic or functional neuropsychiatric disorder may be predisposed to develop cerebral complications under the impact of the arsenical drug. The brain of such individuals may constitute a locus minoris resistential potentially more susceptible to brain damage than that of so-called normal individuals.

SUMMARY

A survey of the literature on hemorrhagic encephalopathy during or following five-day treatment with mapharsen reveals a mortality rate of only 25% from that complication in contrast to a fatality percentage of 76% under the same mode of administration of other arsenicals. The relative benignance of that complication is confirmed by the case of a fifteen year old girl with early syphilis who developed typical symptoms of hemorrhagic encephalopathy on the third day following completion of a five-day treatment course with a total of 1.2 gm. of mapharsen. Final ecovery was established nine days following the onset of the cerebral incident.

The role of the therapeutic agents employed is discussed and the use of high doses of ascorbic acid recommended.

In the search for an explanation of the affective selection of this complication, attention is drawn to the psychopathic behavior of the present case prior to hospitalization and findings in the literature recording nervous or mental deviation in patients who later developed hemorrhagic encephalopathy. It may be tentatively conjectured that an individual known to be afflicted with signs of an organic or functional neuropsychiatric disorder may be predisposed to develop cerebral complications under the impact of the arsenical drug.

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THE ILLINOIS HOSPITAL SURVEY

ROLAND R. CROSS, M.D.

Director, Illinois Department of Public Health

SPRINGFIELD

On national, state, and local levels at the present time there is a great deal of constructive thinking and some action regarding the availability and adequacy of hospital facilities in rural and urban areas. To conduct an unbiased and thorough study of present hospital service in the United States the Commission on Hospital Care, a non-government public service committee was organized. This Commission, under the direction of Doctor A. C. Bachmeyer, has been responsible for the instigation of independent studies in fourteen states to date and has spent a tremendous amount of effort in designing Schedules of Information which may be used in the acquisition of salient data on hospitals.

In May, 1945, upon the recommendation of the Commission, the American Hospital Association, and the Illinois Hospital Association, Governor Green authorized the Illinois Department of Public Health to make a detailed statewide survey of facilities for bed care of the sick. The institutions to be included in this study are all hospitals, convalescent homes, and nursing homes, both public and private. In addition, clinical and allied facilities available through local health departments will be appraised. The data relating to the number and type of beds,

equipment, personnel, location, accessibility and fiscal status of the institution as well as the geography and economics of the environs, will be assembled on voluminous Schedules of Information sent out to each institution.

The information so gathered will be subject to analysis by the Commission on Hospital Care as a part of the national survey, and of more interest to the citizens of Illinois, this data will be of basic importance in the state study. To assist the Department in the conduct of this Survey and in the interpretation and utilization of the findings, the Governor has appointed an Advisory Council of about fifty men and women representing the various key interests in the state. The Chairman of this Council is Doctor Robert S. Berghoff, President Elect of the Illinois State Medical Society. The membership of the Advisory Council is as follows:

Herbolsheimer, Dr. Henrietta, Executive Secretary, Springfield, Illinois Department of Public Health. Allen, Dr. Raymond B, 1853 West Polk Street, Chicago, Dean, College of Medicine, University of Illinois. Barrett, Rev. John W., 31 East Congress Street, Chicago, Chairman, Commitee on Government Relations, Illinois Hospital Assn. Bourscheidt, Dr. Paul F., Central Illinois Hospital Service, Peoria, Blue Cross Plan. Bryan, Dr. W. J., 1601 Park View, Rockford, President, Illinois Tuberculosis Association. Burns, Mrs. Kathryn Van Aken, 206 Women's Building, Urbana, Extension Service in Home Economics, University of Illinois. Butler, Mrs. E., Box 192, Alton, Health Chairman, Illinois Congress of Parents and Teachers. Canty, Mr. Arthur, 343 South Dearborn, Chicago, Commander, Illinois Department, American Legion. Christenson, Mrs. Frank C., 1637 51st Street, Cicero, Health Chairman, Illinois Federation of Women's Clubs. Clippinger, Mr. Roy, Carmi, Publisher, The Democrat Tribune. Cross, Lt. Governor Hugh, Springfield, President, Illinois State Senate. DeBuek, Dr. Roger W., Evanston Hospital, Evanston, Chicago Hospital Council. Donnelly, Mr. James L., 120 S. LaSalle Street, Chicago, Executive Vice-President, Illinois Manufacturers Association. Dudley, Dr. Gerry B., Charleston, Illinois State Medical Society. Eckert, Mr. E. A., Route 2, Mascoutah, Master, Illinois State Grange. Erikson, Mr. Carl, Schmidt, Garden & Erikson, Architects, 104 S. Michigan Ave., Hospital Architect, Chicago. Falls, Dr. Frederick H., 1853 West Polk, Chicago, College of Medicine, University of Illinois. Fisher, Mrs. Walter T., 225 N. Michigan Avenue, Chicago, President, Illinois League of Women Voters. Gatton, Mr. J. L., St. John's Sanitarium, Springfield, Illinois Conference of the Catholic Hospital Association. Green, Hon. Hugh, Jacksonville, Speaker, Illinois House of Representatives. Hilliard, Mr. Raymond N., 160 North LaSalle, Chicago, President, Illinois Welfare Association. Hummel, Stuart K., Silver Cross Hospital, Joliet, Committee on Government Relations, Illinois Hospital Assn. Hutton, Dr. James N., 30 North Michigan Avenue, Chicago, Illinois State Medical Society. Lawson, Miss Elizabeth, Charleston, Past President, Ill. Division American Assn. of University Women. Lay, Mr. Chester Lay, Carbondale, President, Southern Illinois Normal University. Levin, Mr. S., 333 South Ashland, Chicago, President, Ill. State Union Council, Congress of Industrial Organizations. Linck, Mr. Lawrence J., 427 North Vine, Hinsdale, Exec. Sec., National Association for Crippled Children & Adults. Lindstrom, Prof. D. E., 300 New Agriculture Building, Urbana, Chairman, Community Relations Seminar, University of Illinois. Lunde, Mrs. Laura, 6708 Olympia, Chicago, Secretary, Illinois Women's Conference on Legislation. Lyerla, Mr. O. W., Herrin, Southern Illinois Incorporated. McNealy, Dr. Raymond W., 720 North Michigan Avenue, Chicago, Illinois State Medical Society. McNulty, Dr. Robert W., 1574 West Harrison, Chicago, President-Elect, Illinois State Dental Society. MacEachern, Dr. Malcolm T., 40 East Erie Street, Chicago, Associate Director, American College of Surgeons. Mathias, Mr. Paul E., 608 South Dearborn Street, Chicago, Illinois Agricultural Association. Nelson, Mr. Oscar, 11 South LaSalle, Chicago, Executive Secretary, Illinois Postwar Planning Commission. Nicholson, Miss Edna, 343 South Dearborn, Chicago, Director, Central Service for the Chronically Ill. Nickell, Mr. Vernon L., Springfield, State Superintendent of Public Instruction. Poust, Brig. Gen. Cassius H., Springfield, Director, State Department of Public Welfare. Ryerson, Mr. Edward L., 160 North LaSalle Street, Chicago, Chairman, Illinois Public Aid Commission. Sargent, Mr. A. L., 537 South Fourth, Springfield, Director, Illinois Municipal League. Shaughnessy, Dr. Howard, 1800 West Filmore, Chicago, President-Elect, Illinois Public Health Association. Smith, Dr. Herman M., Chicago, Director, Michael Reese Hospital. Soderstrom, Mr. R. G., 503 Security Building, Springfield, President, Illinois Federation of Labor. Stephens, Mr. Robert, First National Bank Building, Springfield, Secretary, Illinois State Bar Association. Stevenson, Dr. Walter, 510 Maine Street, Quincy, Illinois State Medical Society. Wanless, Mr. Fred, 317 South Fifth Street, Springfield, Realtor, Hospital Boards. Wham, Mr. Benjamin, 231 South LaSalle, Chicago, Chairman, Illinois Statewide Public Health Committee. Wolfer, Dr. John A., 700 North Michigan, Chicago, President, Society for Control of Cancer. Van Horn, Miss Ella, 160 North LaSalle, Chicago, Coordinator of Schools of Nursing, Nurse Examining Committee, Department of Registration and Education.

A survey of the extent of the Illinois Hospital Survey is a large responsibility and will in all probability be an enormous amount of work for hospital superintendents in making information available; for the Health Department and the Advisory Council in analyzing the data, establishing standards, and formulating state plan. Out of thinking and planning based on knowledge of locally existing facilities and needs, we may rightfully expect recommendations that will guide those groups in local communities who wish to provide optimally for their demands for hospital care. There should be fewer duplications of facilities, fewer constructions altruistically conceived but economically unsound, fewer areas that are devoid of good hospital service. And from such planning we might anticipate a coordinated system of hospitals making available complete care and modern equipment to all the people in our state and country, wherever they may be.



Physical Medicine Abstracts

John S. Coulter, M.D.

THE EFFECT OF ULTRAVIOLET IRRADIATION ON THE BLOOD HEMOGLOBIN

Adelaide P. Barer, Ph.D., and Willis M. Fowler, M.D.
Iowa City, Iowa

In THE JOURNAL OF LABORATORY AND CLINICAL MEDICINE, 30;7;603
July, 1945

These results indicate that ultraviolet irradiation produces a very slight but persistent increase in the blood hemoglobin level. The increase is not great enough to recommend this as a routine therapeutic procedure in hypochromic anemia, although it may sometimes be useful as a supplement to other forms of therapy in selected cases.

MANAGEMENT OF PELVIC INFLAMMATORY DISEASE OF GONORRHEAL ORIGIN

M. Ray Gottesfield, M.D., Denver, Col.

In ROCKY MOUNTAIN MEDICAL JOURNAL, 42;7;517
July, 1945

Medical Management

1. Acute phase
 a. The patient is placed in a low Fowler's position to facilitate drainage into the pelvis by gravitation.
 b. Complete bed rest.
 c. Sedation sufficient to relieve pain.
 d. Parenteral administration of fluids (approximately 3,000 cc. per day) until the patient can tolerate fluids by mouth.
 e. Low residue diet.
 f. Daily elimination by enemata, supported by oral administration of mineral oil.
2. Chronic phase
 a. Foreign protein—10 cc. given intramuscularly every third day.
 b. Elliott treatment or diathermy.
 c. Avoidance of all sex trauma.
 d. Hyperpyrexia: this is particularly valuable in gonorrheal arthritis.
 e. Bartholin glands require surgical removal.
 f. Skenes ducts drained or excised.
 g. The cervix — cauterization with silver nitrate or the cautery knife. Occasionally the Sturmdorf operation, or actual amputation of the cervix, may be considered.
 h. Chemotherapy

PHYSICAL THERAPY IN THE TREATMENT OF ARTHRITIS

Shelby Gamble, M.D.

In THE PHYSIOTHERAPY REVIEW, 25;4;166
July-August, 1945

Heat in its various forms, massage, and exercise are the basic agents in all treatments. A heat cradle with two to four 60-watt light bulbs over the involved knees and ankles for one-half to one hour three times daily not only gives continued infra-red baking but also keeps the weight of the covers off the painful joints.

As the patient becomes ambulatory, he receives additional treatment once or twice daily in the physical therapy department.

Depending on the individual case we have a slight preference for the paraffin bath, primarily because afterward the skin is in good condition for massage without additional lubricants. When the regimen is prolonged, the skin does not tend to become as dry or raw and edematous with the paraffin baths as with the whirlpool baths. However, in any condition with a wound there is no substitute for the whirlpool bath, and the gentle massaging effect does much, especially if

there is little time or a shortage of technicians to carry out manual massage afterward.

Sunlight and artificial ultraviolet irradiation are valuable as general tonic measures, even though they have no proved scientific effect.

Common ion transfer, using either histamine or mecholyl as visodilating drugs, is said to be of value applied locally to a joint which does not respond to ordinary measures. Our experience with this form of treatment is limited, because we prefer to use the more common methods.

Fever therapy in arthritis is an important agent. Intravenous typhoid vaccine is very satisfactory for the production of fever. Fever therapy by means of a cabinet is very time consuming and highly specialized. Adequately trained personnel is of utmost importance, and during the present shortage of technicians we have dispensed with this form of treatment.

The importance of exercise is generally disregarded. As our service hospitals have dramatically shown, it takes only a few simple movements a day to keep a joint from becoming ankylosed when immobilized.

Disregarding arguments for and against passive and active exercise, each joint in the beginning, after heat and massage have been applied, should be put through as full a range of motion as possible without undue distress to the patient. If the patient cannot do this for himself, passive motion is indicated to maintain joint movement, because muscle weakness or substitution is not a factor as it is in certain other conditions.

INTERNAL DERANGEMENTS OF THE KNEE IN MILITARY PRACTICE

Hewson I. J. Kellam, M.D., F.R.C.S. (E.)

In THE CANADIAN MEDICAL ASSOCIATION JOURNAL, 53;2;147 August, 1945

An internal derangement of the knee is a common condition for which a soldier may seek medical advice, and is second only in frequency to orthopaedic conditions occurring about the foot and ankle.

The aim of treatment is to obtain a painless stable knee with intact ligaments, a full range of movement and a strong fully developed quadriceps muscle. All writers are agreed that active exercise is the method to obtain such a goal. The most important muscle so far as the knee joint is concerned is the quadriceps expansion and no knee is considered normal without full support of this structure. In our cases quadriceps-setting drill is commenced at least 48 hours prior to meniscectomy and resumed 48 hours after operation. Preoperative instruction in quadriceps exercises teaches the patient how to perform the act and is easily re-established following operation. By the third day the soldier can raise his leg off the bed. Exercises are given twice daily for 15 minutes, supervised by an Army Physical Training Corps instructor, and every hour for five minutes by the nursing sister in charge of the ward. On the 10th day the patient is allowed out of bed for half an hour and therafter for longer periods according to his tolerance. During the third and fourth weeks in hospital the soldier attends the gymnasium for more strenuous exercises including quadriceps drill against resistance. Cases with minor degree of fluid within the joint have the knee strapped with elastocrepe bandage.

Severe postoperative effusion is very uncommon and where necessary this is aspirated to relieve tension and prevent attenuation of the cruciate ligaments.

THE PRESENT STATUS OF THE EARLY TREATMENT OF POLIOMYELITIS

John A. Toomey, M.D., Cleveland, Ohio

In THE WISCONSIN MEDICAL JOURNAL, 44;8;785 August, 1945

Putting a patient in a fixed cast and keeping him there does not allow for maintenance of circulation and nutrition to the best advantage. Such treament will probably do the patient harm; physiotherapy and reeducation are not started early enough in this group.

No one has demonstrated that immobilization for short periods of time, a few weeks or so, harms the patient. If, in addition, the patient gets physiotherapy daily, the results will be good. This has been conclusively demonstrated by the Baltimore group.

Good results can be secured in the primary and secondary phases of the disease with the Kenny treatment as well. Her patients are lax. Statistics may not always give a good idea as to the betterments conferred by her method. But here again, the results are not due to any particular therapy but to persistent physiotherapy. The method is expensive, requiring a large number of nurses and technicians. This is beside the point,

however, if it were conclusive in all instances, but it, too, has its failures as can be seen from the report of the first 27 cases treated by the Minneapolis group.

No matter what treatment is applied, the results will depend upon the enthusiasm, knowledge, patience, and perseverance of physiotherapy and muscle reeducation employed by the individual who cares for the patient.

FREEZING TREATMENT OF TUMORS
(Preliminary Communication)

Frederick M. Allen, M.D., Frank K. Safford, Jr. M.D., and Lyman Weeks Crossman, M.D., New York

In ARCHIVES OF PHYSICAL MEDICINE, 26;8;501 August, 1945

A salient feature of this treatment is the freezing with carbon dioxide ice for longer periods than have heretofore been employed. Our maximum thus far has been a ten minute application with pressure, repeated three times, but the actual tolerance limits is not yet established. The longer periods provide deeper penetration of the cold and increase the degree and extent of the ensuing inflammation. Too long an application must cause an indiscriminate necrosis of tumor and normal tissue, like the massive freezing methods of the previous century. The item of essential interest is the seemingly selective necrosis of the neoplasm, so that apparently every tumor cell dies and every normal cell survives. The high resistance of cancer cells to cold, which is familiar in the literature, furnishes one argument for the still tentative hypothesis that the destruction is somehow connected with the ensuing inflammation and thus may be identical with the results of temporary local asphyxia.

On this assumption, the effects of freezing are radically different from those of cautery, of either the thermal or the electric kind. In addition, the practical painlessness of the freezing treatment eliminates the need for anesthesia, and even if the duration is extended to the point of killing some normal tissue, the peculiarity of the healing process is such that, within certain limits, a disfiguring or deforming scar need not be anticipated. The ideal, however, is to obtain selective necrosis of the tumor with no lasting damage to the normal tissues.

FRACTURES ABOUT THE ELBOW IN CHILDREN

Harold B. Boyd, M.D., and A. Ralph Altenberg, M.D., Memphis

In THE JOURNAL OF THE TENNESSEE STATE MEDICAL ASSOCIATION, 38;8;245 August, 1945

Fractures involving the elbow joint in children are relatively common. In studying the files of the Campbell Clinic, we find that over 700 of these fractures have been treated by members of the staff in individuals twelve years of age or under. This does not include the fractures treated on the service at the John Gaston (City) Hospital.

Physical therapy is rarely necessary in a child. Full motion might be obtained quicker by the use of physical therapy, but the time element is of no economic importance to a child. Gradually increasing active motion is safer and much cheaper than passive motion and massage carried out by a physical therapist.

THE SURGICAL TREATMENT OF INJURIES OF THE BRAIN, SPINAL CORD, AND PERIPHERAL NERVES

John E. Scarff, M.D., F.A.C.S., Lieutenant Colonel, M.C., A.U.S., New York New York. In SURGERY, GYNECOLOGY AND OBSTETRICS, 81;4;424 October, 1945

Physical and mental rehabilitation of patients who have received a craniocerebral injury requires good judgment and skill. The patient must be encouraged in every way to think that the injury has been only a slight one. Terms like "concussion of the brain" and "compound fractures of the skull" must be absolutely forbidden, and in the presence of the patient such simple terms as "bump on the head" and "cut on the head" substituted. Lumbar punctures in conscious patients are usually unnecessary and are particularly to be avoided. They add little useful knowledge, have little therapeutic value, and leave a deep and bad psychological scar. An arbitrary period of bed rest for 2 to 3 weeks, as was formerly practiced, is no longer approved. Instead, as soon as the patient feels able to sit up or go to the lavatory, or to have his meals, he should be allowed to do so. He should be encouraged to participate in the care of his room and his own person. Physical therapy including

passive motion, baking, massage and electrical stimulation, should be directed to paralyzed limbs.

Recovery of function in extremities and sphincters after severe spinal injury may require weeks or even months. If meticulous care of the skin, bladder and limbs, including massage, passive motion of joints and corrective splinting, be maintained, many seemingly hopeless cases will recover a great measure of useful function.

In Peripheral Nerve Injuries physical therapy should be instituted about the third week after suture. This should include daily massage, to improve circulation; passive and active motion to keep joints, tendons and muscles supple; and galvanic stimulation, applied directly to individual denervated muscles, to preserve the contractility of muscle element and to prevent the atrophy of disuse. The minimum effective galvanic stimulation consists of 30 contractions of each paralyzed muscle, repeated three times daily, three days each week. More frequent stimulation is, of course, desirable.

Splints should be used as needed to reenforce weakened or paralyzed muscles and prevent contractures; but these splints should be of such a type as to allow free, voluntary, and passive movements of all joints. If plaster-of-Paris splints are used they should be worn only at night, and left off during the daytime, and the patient encouraged to carry out maximum passive and active movements during his waking hours.

NORMAL PHYSIOLOGIC DOUCHES

K. J. Karnaky — P. 107

In AMERICAN JOURNAL OF SURGERY, NEW YORK, 69;1-140 (July) 1945

Abstracted in THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 129;5;408 September 29, 1945

Karnaky points out that many physicians are still prescribing alkaline substances, sodium pergorate, borax, sodium bicarbonate, potassium permanganate, magnesium sulfate and sodium chloride or a combination of these, in the treatment of vaginal leukorrhea or as a cleansing douche when it is scientifically established that the normal hydrogen ion concentration of the adult vagina is acid. He thinks that acid douches (ph 3.0 to 5.0) should be used, because with pathologic changes there is hypo acidity of the vagina, and, as these changes increase, the hydrogen ion concentration approaches the alkaline side. Alkaline douches favor the growth of pathogenic organisms. The best douche found in ten years of research is vinegar. The patient should be instructed to use 5 tablespoons of vinegar to the douche bag if there is an acute vaginitis. After two weeks, 2 to 3 tablespoons is used instead of 5. For an ordinary cleansing douche 3 tablespoons of vinegar should be added to the douche bag.

MALUNION OF FRACTURES

R. Broomhead, F.R.C.S.

Orthopaedic Surgeon, General Infirmary, Leeds; Lecturer in Orthopaedics, University of Leeds.

In THE PRACTITIONER, 926;155;80 August, 1945

Treatment of established malunion. — Since there is a tendency at the present time to devise more and more elaborate operations, it may perhaps be as well to stress that much can be done by relatively simple methods for patients with malunion; and it must be borne in mind that the aim is to improve function, not a skiagram. It is no great surgical triumph to produce a skiagram with correct alignment if function is no whit better. There is nothing more fallacious than x-ray diagnosis and treatment.

If a patient has a malunited fracture his loss of function is often due to loss of movement, but that loss of movement is not certain to be due to bony causes. Loss of movement is often due to adhesions of soft parts which can be broken down and mobilized by careful, and possibly repeated, manipulations under anesthesia. If such procedures are interspersed with periods of concentrated physiotherapy, although there may not be a full return of normal function, it may be possible to restore enough movement to give the patient adequate function, and major operations may be evaded. This is particularly so when the fracture has been in the region of a joint.



News of the State

PERSONALS · COMING EVENTS · MARRIAGES · DEATHS

BUREAU COUNTY

Captain E. H. Schnicke of Wyanet is home on leave after 31 months of overseas duty. He wears the Bronze Star, the Medical Combat Badge and the North African and European campaign ribbons with three major campaign stars. He will soon report to Camp Breckenridge, Kentucky, for further assignment.

CHAMPAIGN COUNTY

Adrien Verbrugghen addressed the Champaign County Medical Society at a dinner meeting on October 11th. He spoke on "Neurosurgical Problems in Children and Adults."

COOK COUNTY

Paul B. Magnuson of Chicago will leave his present post as associate professor of Surgery at Northwestern University Medical School to devote his full time toward development of opportunity for medical personnel of the Veterans Administration to increase their skills through medical research and postgraduate work leading to specializing in medicine and surgery. He will have charge of developing research programs for the Veterans Administration, in conjunction with consultants in special medical fields, formulation of training policies for medical personnel and establishment and operation of all schools or courses of instruction on professional subjects for V.A. doctors.

Carl A. Dragstedt, Chairman of the Department of Pharmacology at Northwestern University gave a talk on Penicillin before the Park Ridge Kiwanis Club, September 26th.

Dr. Leon O. Jacobson, assistant professor of medicine at the University of Chicago, has been appointed associate dean of the university's division of biological sciences, President Ernest C. Colwell has announced.

Dr. Jacobson, who has been associate director of the biology and medicine division of the metallurgical project at the University of Chicago for the past three years, was made a staff member of the department of medicine at the university in 1941.

He received his doctor of medicine degree from the University of Chicago in 1939 and his bachelor of science degree from the North Dakota Agriculture College in 1935.

Warren Cole, Chicago, Professor of Surgery at the University of Illinois College of Medicine spoke on "Treatment of Surgical Lesions of the Stomach including Pre- and Post-Operative Care" before a joint meeting of the Wisconsin Academy of Surgery and the Jackson Clinic Post Graduate Group at Madison, Wisconsin, on October 19.

Lt. Col. George A. Wiltrakis of Chicago has been appointed deputy director of medical and surgical service of the Illinois Public Welfare Department. Formerly with the public welfare department for 11 years and superintendent of the Alton and Peoria state hospitals, Doctor Wiltrakis has served in the Army Medical Corps since February, 1941.

Jack Friedman of Chicago has been promoted from Major to Lt. Colonel.

Miss Harriet Fulmer of Chicago, first president and founder of the Illinois State Nurses Association in 1901, was a special guest of the association on October 19th at Peoria, at a dinner meeting of the Association. Miss Fulmer was responsible for the first public health nursing in the state when she organized a system of Health Chore cards to make pupils conscious of health habits. In Miss Fulmer's honor a double barred red cross is now erected on RR 1 near Carmi, the county seat of White county, where she first began the health card checking system which was used for many years in the state and throughout the nation.

J. Milo Anderson, assistant superintendent of the University of Chicago Clinics and superintendent of the Chicago Lying-In Hospital and Dispensary, was to take over a new appointment as administrator of the Methodist Hospital, Gary, Ind., August 15.

Mr. Robert M. Cunningham Jr., associate editor of *Hygeia*, has been named managing editor of the *Modern Hospital* of Chicago, succeeding Alden B. Mills who left October 13 to become superintendent of the Huntington Memorial Hospital, Pasadena, Calif. In addition to his work on *Hygeia*, which is the health magazine of the American Medical Association, Mr. Cunningham has been since 1937 director of public relations on a part time basis for Evanston Hospital, Evanston, Ill. He has written extensively for national magazines on medical and related topics. Before joining *Hygeia* in 1941, Mr. Cunningham was for three years a member of the staff of the Chicago Plan for Hospital Care, the nonprofit hospital prepayment organization. He served variously as assistant to the executive director, head of the hospital department and director of enrolment and public relations.

Effective September 1 the following members of the faculty at the University of Illinois College of Medicine have been promoted to the rank indicated:

Dr. Arthur R. Cooper, Oak Park, Ill., to professor of anatomy.

Dr. Roy L. Webb, Charleston, W. Va., to professor of anatomy.

Dr. Abraham R. Hollender, Miami, Fla., to professor of otolaryngology.

Dr. Warren S. McCulloch, to professor of psychiatry.

Dr. William H. Cassels, to professor of surgery.

Robert H. Krehbiel, Ph.D., to associate professor of anatomy.

Dr. Oliver E. VanAlyea, to clinical associate professor of otolaryngology.

Dr. Richard W. Watkins, to clinical associate professor (Rush) of otolaryngology.

Dr. Ford K. Hick, Oak Park, Ill., to associate professor of medicine.

Dr. Theodore J. Wachowski, to associate professor of radiology.

Dr. Benjamin D. Braun, to clinical assistant professor of radiology.

Dr. Harold C. Lueth, Evanston, Ill., to associate professor of medicine.

Dr. James B. Eyerly, to clinical professor of medicine.

Dr. Loren W. Avery, to clinical professor of neurology.

Dr. Ben W. Lichtenstein, to associate professor of neurology.

Dr. Hiram J. Smith, to associate professor of ophthalmology.

Dr. Carl Apple, to associate professor of ophthalmology.

Dr. Louis Bothman, to clinical professor of ophthalmology.

Dr. Ralph Spaeth, to assistant professor of pediatrics.

Dr. Gertrude E. Howe, Cincinnati, to assistant professor of pediatrics.

Dr. Carl Ireneus Jr., to assistant professor of surgery.

Dr. Roy O. Riser, Park Ridge, Ill., to assistant professor of ophthalmology.

This year for the first time the University of Illinois is using the word clinical for its part time faculty members who are in the clinical departments.

Dr. John J. Madden was chosen president of the Illinois Psychiatric Society at its annual meeting recently. Other officers include Drs. Frances Hannett, vice president, and Charlotte G. Babcock, secretary-treasurer, all of Chicago.

Northwestern University has received $10,000 to establish a fund for "research into the cause and cure of cancer and the amelioration of suffering from that disease." The gift was made by Miss Edith L. Patterson as a memorial to her brother, Floyd Elroy Patterson, to augment a contribution of $575,000 made to Northwestern University in 1933 for the maintenance of the Patterson Cancer Clinic on the Chicago campus and to serve as a nucleus to establish the new fund.

CRAWFORD COUNTY

The Crawford County Medical Society met at Robinson on October 11th with Doctor John R. Taylor of Palestine discussing "The Present Status of Penicillin."

KANE COUNTY

Harold Voris of Chicago addressed members of the Kane County Medical Society, October 1, at a meeting held at St. Joseph's Hospital, Aurora. His subject, illustrated with motion pictures, was "Operative Management of Inter-Cranial Hemorrhage."

LAKE COUNTY

K. C. Beck of Waukegan has been appointed a member of the board of examiners of the Illinois Bell Telephone Company's program for reemployment of over 1,500 returning veterans.

LIVINGSTON COUNTY

Guy F. Turner of Long Point was entertained at a dinner recently in recognition of his completion of forty years of service as postmaster. He retired from the position on August 31. The

celebration was also said to be in honor of Doctor Turner's birthday.

MADISON COUNTY

The following officers were elected at a recent meeting of the staff of St. Elizabeth's Hospital, Granite City: President, David Friedman of Madison; Vice-President, D. G. Cariss of Granite City; and Secretary, Doctor J. R. Chaflin of Venice.

McDONOUGH COUNTY

The following officers have been elected to serve for the coming year by the McDonough County Medical Society: President, W. E. Carnahan; First Vice-President, A. P. Standard; 2nd Vice-President, Bill Standard; Secretary-Treasurer, W. M. Hartman.

Elizabeth R. Miner of Macomb was presented with a certificate in the 50 year club of the Illinois State Medical Society, at the October 11th meeting of the McDonough County Medical Society. The presentation was made by Doctor Charles P. Blair of Monmouth, Councilor of the 4th District.

Doctor Ruth Church of Washington, Iowa, has been assigned to Macomb as the new health officer for the bi-county (McDonough and Fulton) health unit. Doctor Church, who will assume her duties on December 1st, is a graduate of the University of Wisconsin College of Medicine and has had seven years experience as a county health officer.

MORGAN COUNTY

The Morgan County Medical Society met at Oak Lawn Sanitarium on October 11th as the guests of Dr. Walter C. Reineking, Superintendent. The program, provided by the State Department of Public Health, was given by Doctors Clifton Hall and Leslie Knott. The November meeting was held at the Jacksonville State Hospital. Judge Paul Fenstermaker gave a talk on the revised Mental Health Act in Illinois and Doctor Frederick Andrew Gibbs, University of Illinois College of Medicine, spoke on "Advances in the Diagnosis and Treatment of Epilepsy."

PEORIA COUNTY

The office of the Surgeon General has announced the promotion from Major to Lt. Colonel of Wilbur Lorenzo Bowen of Peoria.

Alexis F. Hartmann, professor of pediatrics at Washington University School of Medicine, spoke on therapy involving the administration of amino acids at the October 16th meeting of the Peoria County Medical Society.

Appointment of Doctor David Fey of Peoria as fire and police surgeon for the city has just been announced by the board of fire and police commissioners of that city.

Walter Baer, former Peoria psychiatrist, returning from military leave, became managing director of Manteno State Hospital at Kankakee on November 1st.

Major Charles F. Sutton, former Chillicothe physician, has been awarded the bronze star medal for meritorious achievement in connection with military operations in Italy.

ROCK ISLAND COUNTY

Four Rock Island county physicians who have practiced 50 years or more were honored at a meeting of the Society on October 9th at which time they were presented with certificates by Dr. Charles P. Blair of Monmouth, Councilor of the 4th District. The doctors receiving the 50 year pins and certificates were Joseph deSilva, Rock Island; W. L. Eddy, Milan; F. H. Gardner, Moline and O. S. Dailey, Port Byron. Doctor Reuben Nomland of Iowa City gave a paper on "Common Skin Diseases."

Captain Clarence S. Costigan, who formerly practiced in Moline, has been awarded the Bronze Star Medal for outstanding service in the European theater.

ST. CLAIR COUNTY

The board of directors of St. Clair County's Pleasant View Tuberculosis Sanatorium announces the appointment of Dr. John C. Wilson, honorably discharged naval commander from Quonset Point, Rhode Island, as director and superintendent of the institution. Doctor Wilson succeeds Doctor Robinson W. Bosworth who has resigned to enter private practice at Rockford, where he formerly lived.

VERMILION COUNTY

Harlan English of Danville has been elected Secretary of the Aesculapian Society.

William M. McMillan of Chicago addressed the Vermilion County Medical Society on November 6th, subject "Primary Resection of the Colon."

School examinations in Danville, under the direction of Doctor Harlan English are progressing as scheduled and will be completed within a very short time.

WARREN COUNTY

After an absence of nearly five years, Doctor Russell Jensen is resuming the practice of medi-

cine in Monmouth. He has been serving as a Lieutenant Commander in the Navy since January, 1941.

WHITESIDE COUNTY

William J. Maurits was elected President of the medical staff of the Morrison hospital, H. L. Pettit was elected Vice-President and R. H. Lester, Secretary and Treasurer at an organization meeting held early in October. The three doctors are all residents of Morrison.

WILLIAMSON COUNTY

Williamson County Medical Society met on November 6th at the Herrin Hospital, Herrin. The program was given by Dr. R. S. Sabine speaking on "The Emergencies in Obstetrics" and Dr. John Hrabic speaking on "The Toxemia of Pregnancy."

DEATHS

Albert H. Andrews, Sr., Chicago; University of Iowa, 1889. Staff member of Wesley Memorial hospital and instructor of otolaryngology at Northwestern University Medical School; oculist for the Chicago, Rock Island & Pacific Railway System. Died October 8th at the age of 83.

Robert Ernest Anthony, Rockford; Hahnemann Medical College and Hospital, 1908. Staff member of Swedish-American Hospital, Rockford. Died September 13th, aged 65.

Otto Budde, Chicago; Northwestern University Medical School, 1895. Had practiced medicine in Chicago for 50 years and was given the golden reunion certificate by Northwestern University this year. Died October 24th at the age of 81.

James Tweedie Campbell, Chicago; Royal College of Surgeons, England, 1890, University of Toronto Faculty of Medicine, 1889, Bellevue Hospital Medical College, New York, 1889. Was senior laryngologist and otologist at St. Luke's hospital. Died October 26th, aged 80.

John Fisher Gainer, Danville; University of Illinois College of Medicine, 1922. Died of a heart attack October 21st, aged 48.

William B. Gray, Canton, retired; Rush Medical College, 1887. Member of Illinois State Medical Society "Fifty Year Club." Died September 22nd after an illness of a few weeks at the age of 88.

Henry Raymond Gross, Chicago; State University of Iowa College of Homeopathic Medicine, 1910. Had practiced medicine in Chicago more than 20 years. Died of a heart attack September 30th, aged 59.

Wladyslaw A. Kuflewski, Chicago; University of Illinois College of Physicians and Surgeons, 1894. Was senior surgeon in St. Mary of Nabareth Hospital and for 25 years was chief medical examiner for the Polish National alliance. Died October 23rd at the age of 75.

William D. Pennington, Chicago; Hospital College of Medicine and Surgery, Louisville, 1893. Died October 23rd, aged 78.

William J. Quigley, Chicago; Rush Medical College, 1913. Had practiced medicine in Chicago for 30 years. Attending physician at County hospital and a member of the staff of St. Anne's hospital. Died in his home, aged 55, on October 1st.

Harry J. Smejkal, Chicago; University of Illinois College of Medicine, 1908. Died October 3rd in St. Anthony's hospital, aged 63.

Joseph John Stasko, Chicago; Northwestern University Medical School, 1944. Commissioned lieutenant (jg) MC, U.S.N.R. on Dec. 18, 1943; served overseas for about 7 months; died in the Asiatic area June 17 while on the hospital ship U.S.S. Refuge, aged 33, of aplastic pernicious anemia.

Annnabel Cleveland Test, Chicago (Not in practice); Northwestern University Woman's Medical School, 1895. Died October 7th in Passavant Memorial Hospital.

Capt. Thomas L. Weber, Olney; Washington University School of Medicine, St. Louis, 1937. Was member of staff of Olney Sanitarium. Enlisted in Army Air Force Medical Corps in November, 1942, and served one year in Alaska. Was drowned September 4th in Lake Kampkaska, South Dakota, when in a routine parachute jump. Was 34 years of age.

Frank H. Westerschulte, Chicago; Rush Medical College, 1895. Had practiced medicine in Chicago for 50 years. Died at his home of a heart attack on October 17th, aged 80.

Letitia A. Westgate, Mendota, retired; Northwestern University Woman's Medical School, 1892. Died at the home farm near Mendota on September 30th.

Clara B. Woodward, Evanston, retired; Jenner Medical College, 1910. Died October 19th in the Presbyterian Home where she had lived since 1935.

Illinois State Medical Society

OFFICERS OF SECTIONS, 1944-1945

SECTION ON MEDICINE
L. E. Hines, Chmn., 104 S. Michigan Avenue, Chicago
W. H. Newcomb, Secy., Jacksonville

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Richard F. Boyd, Secy., Springfield

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P. R. Dirkse, Chmn., St. Francis Hospital, Peoria
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SECTION ON PEDIATRICS
John F. Carey, Chmn., Joliet
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SECTION ON OBSTETRICS & GYNECOLOGY
J. P. Greenhill, Chmn., 55 E. Washington Street, Chicago
E. N. Nash, Secy., Galesburg

SECTION ON PATHOLOGY
H. R. Fishback, Chmn., 303 E. Chicago Avenue, Chicago
M. C. Corrigan, Secy., 2839 Ellis Avenue, Chicago

COUNTY SOCIETIES

This list is corrected in accordance with the best information obtainable at the date of going to press. County Secretaries are requested to notify The Journal of any changes or errors.

County	President	Secretary
Adams	Ralph Hinton, Quincy	Walter Stevenson, Quincy.
Alexander	Howard Stuckey, Cairo	J. S. Johnson, Cairo.
Bond	D. T. Brown, Mulberry Grove	Katherine B. Luzader, Greenville.
Boone	S. J. Smith, Belvidere	M. L. Hartman, Belvidere.
Bureau	J. Harold Hopkins, Walnut	Gerald S. McShane, Spring Valley.
Calhoun	(See Pike-Calhoun)	
Carroll	C. E. Turner, Savanna	W. J. Scholes, Lanark, Ill.
Cass	T. G. Charles, Beardstown	B. A. Desulis, Beardstown.
Champaign	B. Smith Hopkins, Jr., Urbana	J. D. McKinney, Champaign.
Christian	H. M. Wolfe, Taylorville	W. S. Miller, Assumption.
Clark	C. O. Highsmith, Westfield	H. C. Houser, Westfield.
Clay	J. P. Shore, Sailor Springs	D. Curtis Henderson, Clay City.
Clinton	J. A. Bauer, Germantown	J. Q. Roane, Carlyle.
Coles-Cumberland	W. F. Stafford, Mattoon	B. Raymond Cole, Mattoon.
Cook	J. J. Moore, Chicago	W. W. Furey, Chicago.
Crawford	A. L. Lowe, Robinson	J. W. Long, Robinson.
De Kalb	Fred E. Scheppler, Somonauk	Clifford E. Smith, DeKalb.
De Witt	Chas. S. Bogardus, Clinton	Wm. R. Marshall, Clinton.
Douglas	E. J. Gross, Arcola	J. O. Cletcher, Tuscola.
Du Page	L. C. Clowes, Hinsdale	A. R. Rikli, Naperville.
Edgar	H. D. Junkin, Paris	Paul E. Fleener, Paris.
Edwards	E. E. Robert, West Salem	R. L. Moter, Albion.
Effingham	Frank Buckmaster, Effingham	Harry W. Schumacher, Altamont.
Fayette	A. M. Fromm, Ramsey	E. A. Kuehn, Vandalia.
Ford	A. L. Potts, Gibson City	Edward A. Tappan, Paxton.
Franklin	O. L. Rutherford, Christopher	W. T. Harsha, Jr., West Frankfort.
Fulton	W. H. Betts, Havana	P. D. Reinertson, Canton.
Gallatin	E. W. Burroughs, Shawneetown	James A. Kirby, New Haven.
Greene	A. K. Baldwin, Carrollton	W. H. Garrison, White Hall.
Hancock	I. W. Salwitz, Plymouth	Blair Kelly, Ferris.
Hardin	S. E. Oxford, Cave-in-Rock	
Henderson	M. J. Babcock, Biggsville	Elmer T. Swann, Oquawka.
Henry	Worling R. Young, Geneseo	P. J. McDermott, Kewanee.
Iroquois	A. W. Fordyce, Gilman	M. F. Weissman, Milford.
Jackson	Wm. F. Felts, Carbondale	Edward K. Ellis, Murphysboro.
Jasper	Wm. E. Franke, Newton	C. O. Absher, Newton.
Jefferson Hamilton	A. W. Modert, Mt. Vernon	Andy Hall, Mt. Vernon.
Jersey	Hugh R. Bohannan, Jerseyville	Bert M. Brewster, Jerseyville.
Jo Daviess	G. C. McGinnis, Warren	R. E. Logan, Galena.
Johnson	Wm. Thompson, Cypress	E. A. Veach, Vienna.
Kane	S. L. Gabby, Elgin	K. M. Manougian, Elgin.
Kankakee	G. W. Morrow, Kankakee	A. L. Nickerson, Kankakee.
Kendall	No Society	
Knox	Wm. Johnson, Galesburg	G. K. Smart, Galesburg.
Lake	H. Floyd Cannon, Waukegan	A. L. Myers, Waukegan.
La Salle	R. I. Barrickman, Streator	F. J. Maciejewski, La Salle.
Lawrence	R. B. Armitage, Lawrenceville	L. W. Frame, Lawrenceville.
Lee	Zolton Glatter, Dixon	J. M. Lund, Dixon.
Livingston	O. L. Bettag, Pontiac	E. G. Beatty, Pontiac.
Logan	Chester Davis, Lincoln	R. Lynn Ijams, Atlanta.
McDonough	W. E. Carnahan, Macomb	W. M. Hartman, Macomb.

*Deceased.

(Continued on page 50)

(County Officers Continued)

McHenry	Glen E. Wright, Woodstock	George H. Pflueger, Crystal Lake
McLean	G. E. Hartenbower, Bloomington	H. R. Watkins, Bloomington.
Macon	R. A. Tearnan, Decatur	C. R. Fisher, Decatur.
Macoupin	A. C. Goff, Staunton	D. J. Zerbolio, Benld.
Madison	J. W. Kempff, Highland	E. F. Moore, Collinsville.
Marion	H. L. Logan, Salem	H. O. Williams, Centralia.
Mason	C. H. Stubenrauch, Havana	W. A. Steele, Havana.
Massac	V. M. Timm, Metropolis	G. F. Cummins, Metropolis.
Menard	T. V. Plews, Petersburg	H. P. Moulton, Petersburg.
Mercer	Nellie E. March, Aledo	V. A. McClanahan, Aledo.
Monroe	E. T. Lark, Columbia	**J. A. Werth, Waterloo.
Montgomery	George A. Telfer, Hillsboro	C. H. Sihler, Litchfield
Morgan	W. H. Newcomb, Jacksonville	Carl E. Black, Jacksonville.
Moultrie	R. C. Coffey, Bethany	W. B. Kilton, Sullivan.
Ogle	L. R. McDaniel, Polo	A. R. Bogue, Rochelle.
Peoria	Fred Decker, Peoria	W. E. Owen, Peoria.
Perry	G. H. Gutridge, Du Quoin	H. I. Stevens, Tamaroa.
Piatt	A. M. Bruner, Bement	W. N. Sievers, White Heath.
Pike	James Goodman, Pleasant Hill	Myer Shulman, Pittsfield.
Pope		L. S. Barger, Golconda.
Pulaski	Oscar Karraker, Olmstead	Otis T. Hudson, Mounds.
Randolph	J. W. Beare, Chester	W. W. Fullerton, Steeleville.
Richland	Alexis T. Telford, Olney	H. N. Fisher, Olney.
Rock Island	L. A. Dondanville, Moline	N. C. Barwasser, Moline.
St. Clair	James Bellinger, East St. Louis	F. E. Bihss, E. St. Louis.
Saline	*G. C. Ferrell, Eldorado	Neva Skelton, Eldorado.
Sangamon	Fred P. Cowdin, Springfield	M. E. Rolens, Springfield.
Schuyler	A. W. Ball, Rushville	H. O. Munson, Rushville.
Scott	No Society	
Shelby	A. B. Storm, Windsor	C. H. Hulick, Shelbyville.
Stephenson	F. L. Sullivan, Freeport	Samuel H. Bess, Freeport.
Tazewell	Roland C. Wherry, Pekin	Russel K. Taubert, Pekin.
Union	B. V. Rife, Anna	E. V. Hale, Anna.
Vermilion	Robert S. McCaughey, Danville	A. R. Brandenberger, Danville.
Wabash	E. P. Keneipp, Mt. Carmel	H. A. Elkins, Mt. Carmel.
Warren	Ralph Graham, Monmouth	Chas. P. Blair, Monmouth.
Washington	P. B. Rabenneck, Nashville	G. A. Green, Nashville.
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White	C. J. Rosenberg, Norris City	L. R. Medoff, Grayville.
Whiteside	R. H. Lester, Morrison	G. J. Pohly, Sterling.
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Williamson	J. F. McKee, Johnston City	W. W. Ritchey, Marion.
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Woodford	R. E. Gordon, El Paso	W. S. Morrison, Minonk.

*Deceased **In service



No appreciable ciliary inhibition... Benzedrine Inhaler causes "no appreciable change in the amplitude or rapidity of the ciliary beat." Proetz, A.W.: Arch. Otolaryng., 30:509.



In addition, Benzedrine Inhaler, N. N. R., does not give rise to any significant degree of secondary turgescence, atony or bogginess, when used as directed.

The Inhaler is strikingly effective in reducing the congestion accompanying head colds, hay fever, and sinusitis. Each Benzedrine Inhaler is packed with racemic amphetamine, S. K. F., 200 mg.; menthol, 10 mg.; and aromatics. Smith, Kline & French Laboratories, Phila., Pa.

Benzedrine Inhaler

a better means of nasal medication

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In the continuous process of destruction and regeneration of erythrocytes by which the oxygen-carrying capacity of the blood is maintained, the extent of hemoglobin synthesis depends largely on the protein supplied to the organism.

Protein is an essential "raw material" for the formation of the hemoglobin molecule. Unless the protein made available to the organism is adequate in quantity and quality, anemia supervenes.

The only source of the protein required for maintenance of the hemoglobin level is the protein derived from the foods eaten.

Among the protein foods of man meat ranks high—not only because of the percentage of protein contained, but principally because the protein of meat is of high biologic quality—able to satisfy every protein need.

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ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

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THE new light became visible like a dazzling meteor in the evening of the nineteenth century. It surrounded the morning of our own century with the rosy light of hope and promise. Like a glittering sun it shines resplendent on the working day of the twentieth century, revealing new fairways and fresh horizons in nearly every land in the world of science. . . . **In commemorating William Conrad Roentgen this year—the centennial of his birth, also the semi-centennial of his discovery of the x-ray—one is inspired anew by the above tribute spoken by Dr. Gosta Forssell, of Stockholm, Sweden, before the Fifth International Congress of Radiology, held in Chicago in 1937.**

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GENERAL ELECTRIC X-RAY CORPORATION

for more effective

Oral **VITAMIN B COMPLEX THERAPY**

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(U. S. VITAMIN)

3 significant Fractions of Liver

AQUEOUS

LIPOID

80% ALCOHOL-INSOLUBLE

. . . combined with

IMPORTANT CRYSTALLINE B VITAMINS

Current laboratory and clinical investigations show that a combination of the aqueous *and* lipoid fractions of liver, providing more complete nutritional therapy, is clinically superior to aqueous extracts alone . . . since certain essential nutritional factors are removed in the preparation of the usual aqueous liver extracts.

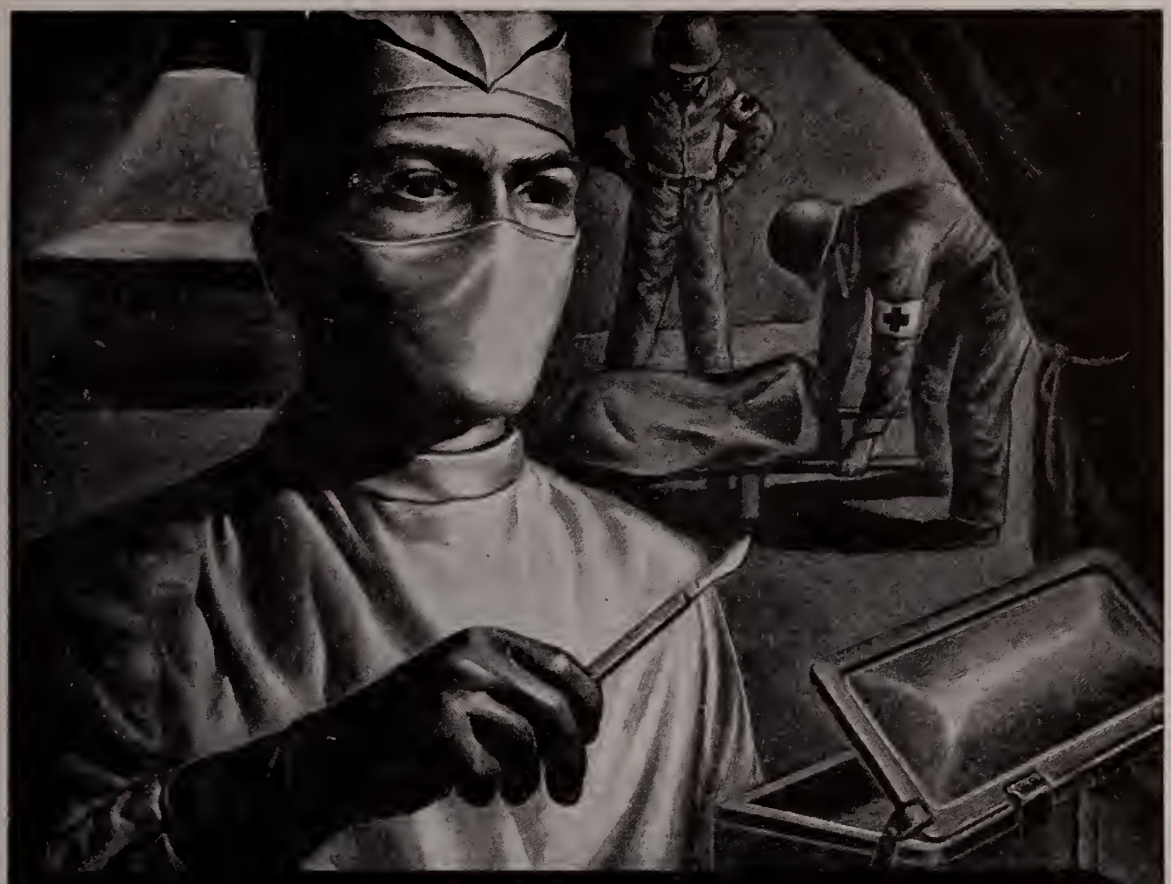


Provides in each capsule the vitamin extracts and concentrate (water-soluble, 80% alcohol-insoluble and lipoid fractions) derived from a total of 11.5 grams of liver . . . including folic-acid fractions (L. casei factor [Bc] etc.), biotin , inositol, and other nutritional factors present in the liver fractions. Each capsule contains:

Thiamine HCl (B_1)	2.0 mg.
Riboflavin (B_2)	2.0 mg.
Niacinamide	10.0 mg.
Pyridoxine HCl (B_6)	0.1 mg.
Calcium Pantothenate	3.0 mg.
Choline	10.0 mg.
Inositol	5.0 mg.
Folic-acid fractions	10.0 mcg.

Professional Samples and Literature

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The Purple Heart—awarded to persons wounded in action against the enemy



THE GUNS are silent once more. For the men with the guns, the war is over. But for the thousands of medical men in the service, the war still goes—their "war in white" in behalf of the wounded, the wearers of the Purple Heart. Doctors that they are, of medicine and morale, they well know how much a cigarette can mean to an invalid soldier. And servicemen that they are, as well, these doctors know what a big favorite Camels have been, and are, with men in all the services.





Camels

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ISOLATED NUTRIENTS

Essential though they are, vitamins are nevertheless not the only nutrients which may be lacking in the diet of persons physically below par. Nutritional imbalance, not infrequently the cause of poor physical stamina, excessive irritability, and poor appetite, may be attributable to other dietary-induced deficiencies. In consequence, adjustment of the entire nutritional intake is indicated.

Virtually any diet can be enhanced to a point of adequacy through the addition of three glassfuls of Ovaltine daily. Made with milk as directed, this delicious food drink supplies liberal quantities of most essential nutrients, as indicated by the table below. Qualitatively Ovaltine is equally valuable; it provides biologically adequate protein, readily assimilated and utilized carbohydrate, well emulsified fat, B complex and other vitamins, as well as essential minerals. Ovaltine proves advantageous both as a mealtime beverage and a between-meal snack. Its low curd tension insures rapid gastric emptying, hence it does not interfere with the appetite for the next meal.

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Ovaltine

Three daily servings of Ovaltine, each made of ½ oz. Ovaltine and 8 oz. of whole milk,* provide:

PROTEIN	31.2 Gm.	VITAMIN A	2953 I.U.
CARBOHYDRATE	62.43 Gm.	VITAMIN D	480 I.U.
FAT	29.34 Gm.	THIAMINE	1.296 mg.
CALCIUM	1.104 Gm.	RIBOFLAVIN	1.278 mg.
PHOSPHORUS	.903 Gm.	NIACIN	7.0 mg.
IRON	11.94 mg.	COPPER	.5 mg.

*Based on average reported values for milk.

Sharp & Dohme

'PROTHRICIN'

Antibiotic Nasal Decongestant containing Tyrothricin and 'Propadrine' Hydrochloride

An antibiotic and vasoconstricting agent for prompt relief of nasal congestion accompanying bacterial infections.

'PROTHRICIN' decongestant provides a double control for the symptomatic treatment of nasal congestion accompanying the common cold, allergic rhinitis, acute catarrhal rhinitis, acute rhinosinusitis and acute ethmoiditis.

An isotonic solution with a *pH of 5.5 to 6.5*, 'PROTHRICIN' decongestant is ideally suited for topical application to the mucous membrane of the nose and accessory sinuses.

The active ingredients of this preparation are:

Tyrothricin (antibiotic) 0.02%
(200 micrograms per cc.)

'Propadrine' Phenylpropanolamine Hydrochloride (vasoconstrictor) . 1.50%

'PROTHRICIN' is applied by means of tampons, irrigation, drops or spray. Supplied in 1-ounce bottles with dropper assembly. Sharp & Dohme, Philadelphia 1, Pa.



FOR CHEER

as well as

NUTRIENT VALUE

THERE are good reasons why candy is appreciated by the hospitalized patient. It brings a note of cheer into the monotonous hospital day. Its taste is relished, even when many other foods fail to tempt the appetite. It aids morale, since it lends a note of "color" to the frequently repetitious hospital diet.

Nutritionally, candy has a place here, too. An adequate caloric intake for the patient usually presents difficulties, not only because of anorexia but because of the very nature of the dietary called for by illness. Candy presents high caloric value in small bulk, concentrated energy.

The utilization of this energy calls for little digestive effort—a point of importance with the hospitalized patient.

In addition, many candies make a contribution to the satisfaction of almost every nutritional need.

THE NUTRITIONAL PLATFORM OF CANDY

1. Candies in general supply high caloric value in small bulk.

2. Sugar supplied by candy requires little digestive effort to yield available energy.

3. Those candies, in the manufacture of which milk, butter, eggs, fruits, nuts, or peanuts are used, *to this extent* also—

a) provide biologically adequate proteins and fats rich in the unsaturated fatty acids;

b) present appreciable amounts of the important minerals calcium, phosphorus, and iron;

c) contribute the niacin, and the small amounts of thiamine and riboflavin, contained in these ingredients.

4. Candies are of high satiety value; eaten after meals, they contribute to the sense of satisfaction and well-being a meal should bring; eaten in moderation between meals, they stave off hunger.

5. Candy is more than a mere source of nutriment—it is a morale builder, a contribution to the joy of living.

6. Candy is unique among all foods in that it shows relatively less tendency to undergo spoilage, chemical or bacterial.

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EXTREMELY SLOW ABSORPTION AFFORDS PROLONGED LOCAL ANALGESIA

A vasoconstrictor is added to most local anesthetics, first—to prevent rapid absorption, and second—to intensify their action.

With Eucupin, however, no such supportive adjunct is required, for Eucupin remains fixed for hours and even days at the site of application; it combines with the protoplasm of the terminal nerve filaments, breaking down slowly enough to afford the otherwise painful area a prolonged period of intense anesthesia and gratifying analgesia.

Thus, when certain procedures and conditions are known to incur long periods of pain, it is obviously futile to attempt to provide enduring control of pain with the common anesthetics. For enduring control, Eucupin is formulated, ready for use, as follows:

EUCUPIN WITH PROCAINE SOLUTION — for surgical anesthesia by infiltration — 30 cc. vials.

EUCUPIN SOLUTION IN OIL — for proctologic anesthesia by infiltration and conservative treatment of low-back pain — 5 cc. ampules, boxes of 6.

EUCUPIN OINTMENT — for topical application to the skin and mucocutaneous junctions — 1 oz. tubes and 1 lb. jars.

EUCUPIN SUPPOSITORIES — for analgesia in anorectal disorders — boxes of 12 (2 x 6).

EUCUPIN

Local anesthetic-analgesic with "staying power"

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IRON...LIVER EXTRACT B-COMPLEX FACTORS

Scientifically combined and processed to supplement nutrition where iron deficiency and B-complex avitaminosis coexist.

Supplied in bottles containing 100 and 500 gelatin capsules

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NOW 400 UNITS OF VITAMIN D_3 PER PINT

The new NESTLÉ'S Evaporated Milk, fed in customary amounts, protects normal infants from rickets *and promotes optimal growth*. 25 USP units of vitamin D_3 are added to each fluid ounce of this milk. So—when you prescribe a NESTLÉ'S Milk formula—you assure a safe, sure and adequate supply of vitamin D.

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FOR THE RELIEF OF URINARY RETENTION

THE subcutaneous injection of ¼ milligram of Doryl, conveniently supplied in 1 cc. ampuls of Doryl Solution, has proved effective in relieving a large percentage of cases of postoperative urinary retention, retention following labor, and retention accompanying certain types of spinal cord lesions. This use of Doryl may obviate the necessity for catheterization with its attendant risk of infection. Two-milligram Doryl tablets are available for oral use when a slower-acting parasympathetic stimulation is sufficient.

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(Carbamylcholine Chloride Merck)
An effective parasympathetic stimulant

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P. R. N.

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by

Charles G. Farnum M. D.
Peoria, Ill.

AN AUTUMN RESOLUTION

He stands by the golf house alone,
He tearfully stifles a groan,
The season is over and not a chance more
Of hoping or trying to lower his score.
He's deluged with sadness, the thing makes him sore.
His grief is expressed by a moan.

The trees are all bare to the gales,
Brown leaves lie in heaps in the swales,
The flags are all out and the tee boxes gone,
There's frost on the greens at the earliest dawn,
The course is deserted of skill and of brawn,
And wind through the underbrush wails.

He played his golf early and late,
Harassed by the cruelist fate,
He tried to break ninety the whole season through.
He took forty lessons as all the dubs do,
The best he could get was freak ninety-two;
His soul effervesces with hate.

This makes him the saddest of men,
Resolving right there and right then,
That nothing shall keep him away from his play,
He'll not waste his winter the usual way,
He's going straight South and not wait until May
to try it all over again.

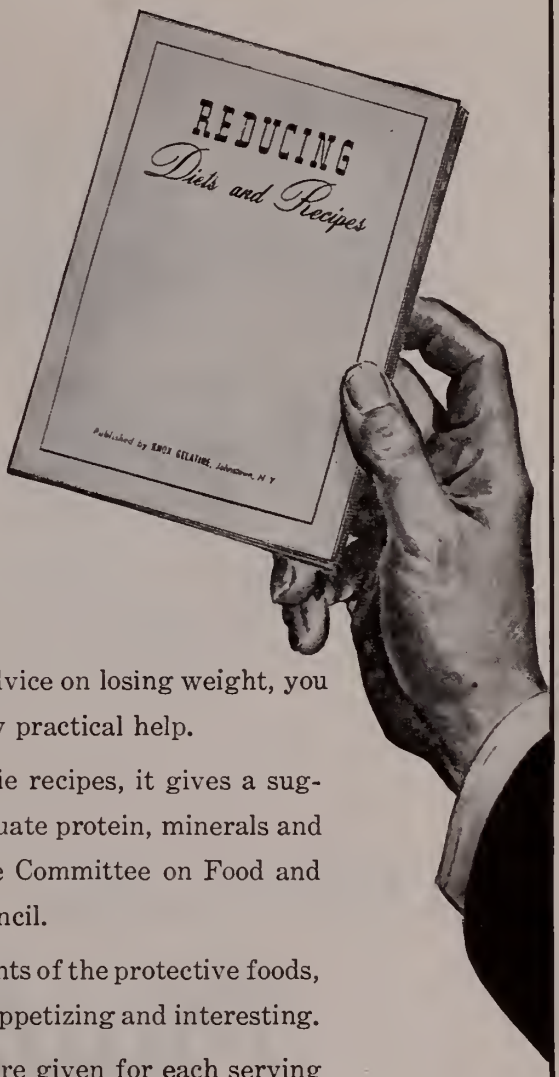
CARDIO-VASCULO-RENAL SYNDROME

You may kid yourself in thinking
That you still are young and spry,
Though your girth is much expanded
And your diastolic's high,
Extra systoles are present
And some day you will succumb;
You may fool yourself and others
But you cannot fool your myocardium.

You may feel just like a million
And have all the world defied,
But the temporals are tortuous
And the radials calcified,
And sclerosis in cerebrals
Brings results you should foresee,

(*Continued on page* 64)

THE BOOKLET MORE AND MORE DOCTORS ARE SENDING FOR...



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P. R. N. (Continued)

Fifth and sixth decades are treach'rous
And you cannot bluff a hardened artery.

You may feel like you are thirty,
But the gravity is low,
Chronic interstitial changes
Cause some hyaline casts to show,
As your N. P. N. goes higher
You are riding for a fall;
You may kid yourself completely
But you cannot kid your kidneys — not at all.

HOPE ETERNAL

With bleak winter in the offing we have given up our golfing and have laid away our clubs another year. As we contemplate the season we can not find any reason for elation, satisfaction or for cheer.

For we recognize in passing that a slice that's most harassing has been with us every day that we have played and our irons too often failed us and our putting has entailed us in some awful scores in spite of how we prayed.

Though our game has been infernal there is hope that springs eternal that next year we'll play a vastly better game. Yet we know this is self-kidding for golf balls won't do our bidding and next Spring will see us do things just the same.

STREPTOCOCCI

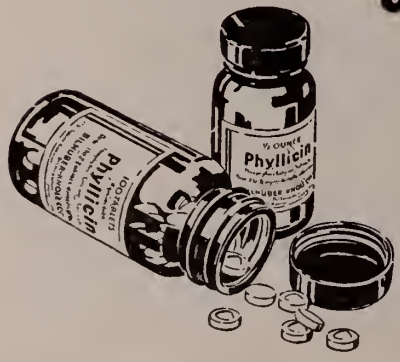
In the past the streptococcus
Was a thing to greatly shock us,
Leaving mem'ries of infections most severe;
But today with aunts and cousins,
Which he numbers by the dozens,
He makes forty new diseases we may fear.

So the modern streptococcus,
As he rises up to block us,
Causes everything from corns to falling hair;
And we simply cannot lose 'em
When they nestle in our bosom,
Or they colonize our insides here and there.

He's a crafty streptococcus
In his rough attempts to sock us
And great hordes of them are daily at us hurled;
It's no use to try to dodge 'em
And we never can dislodge 'em,
And I'll tell it to the streptococci'd world.

For the Failing Heart

Phyllicin



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DOSE: 1 or 2 tablets (4 grains each) after meals.

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Treatment

Relief of pain and inflammatian—*Auralgan.*

Action

Decongestant, analgesic, bacteriastatic.



Otosmosan

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Persistent discharge, often foul smelling, usually no toxemia, no pain, no fever.

Treatment

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Formula

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Book Reviews

MY SECOND LIFE: By Thomas Hall Shastid, A.M., M.D., LL.B., Sc.D., F.A.C.S., F.A.C.P., etc. Illustrated. George Wahr, Publisher to the University of Michigan, Ann Arbor, Michigan. Price $10.00.

Doctor Shastid has once more added an interesting addition to his already long list of books which he has written over a period of years. A native of Illlinois and the son of a pioneer Illinois physician, Doctor Shastid has not only kept notes throughout the years but has shown unmistakable evidence of having an unusually keen memory to be able to relate so many interesting anecdotes throughout the book.

His father, Dr. Thomas Wesley Shastid, born in 1831 in Sangamon County, moved with his family to Pittsfield in 1836 and was graduated from the Medical Department of the University of Missouri, then in St. Louis, in 1856. An older brother of the author, Dr. William E. Shastid, practiced in Pittsfield for many years and was very prominent in the activities of the Illinois State Medical Society for many years. He served one year as our vice president.

The associations of the father and the author with Doctors Hodgen and Mudd as former residents of Pittsfield, are most interesting. Likewise many interesting and amusing stories are told of early Pittsfield. For three years the author was located at Galesburg, and he includes local color and photographs of Galesburg in the "nineties" throughout the book.

Many Illinois physicians and others outside the medical profession, will be intensely interested in this large book and its many stories which make it so entirely different from the usual autobiography, and will place it among the classics in a new field. Many interesting pictures add materially to the interest of the book and these are well chosen and carry reader appeal.

Physicians interested in medical history of Illinois will find much of interest in the volume, and it surely deserves a place not only in medical libraries, but likewise should be found in general libraries throughout the state.

MEN UNDER STRESS: By Lt. Col. Roy R. Grinker, M.C., Army Air Forces, formerly Fellow of the Rockefeller Foundation and Chairman of the Department of Neuropsychiatry, Michael Reese Hospital, Chicago; and Major John P. Spiegel, M.C., Army Air Forces, formerly of the Department of Psychiatry, Michael Reese Hospital, Chicago. The Blakiston Company, 1012 Walnut Street, Philadelphia 5, Pa., 1945. Price $5.00.

The authors in their official duties with the armed forces have had an unusual opportunity to make many hundreds of observations of men under stress in their work with the army air forces. They tell what happens to human beings under terrific strain and show

(*Continued on page* 70)

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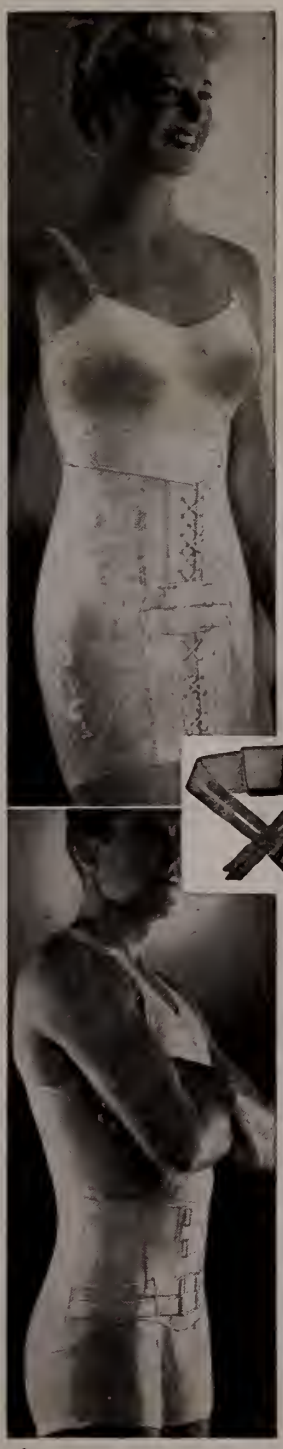
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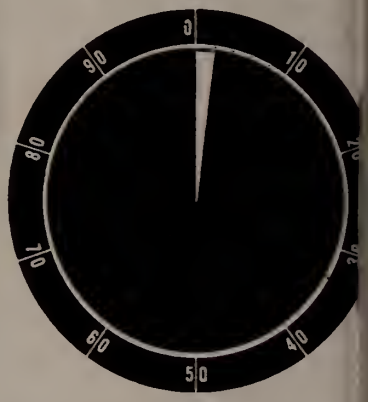
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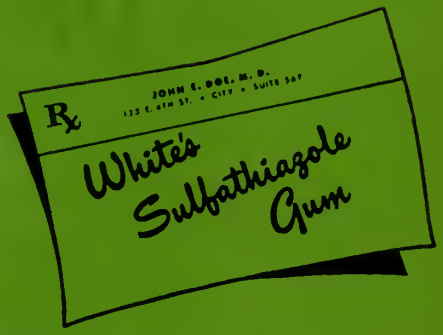
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BOOK REVIEWS (Continued)

the large number of acute neuroses which invariably develop. These authors, having set up the first Army Air Forces Convalescent Hospital for "operational fatigue" in this country are well qualified to evaluate the wealth of information at their disposal.

The book is divided into five parts, the first of which refers to the men, their background and selection. The second part deals with the environment of combat; the third discusses the reactions to combat and morale; the fourth describes reactions after combat, and the fifth part tells of the civilian applications of psychiatry. The psychological mechanism of normal individuals in situations of stress are discussed in a most interesting manner.

Sixty-five case histories covering a large field of reactions have been selected and presented in detail which adds materially to the value of the book. The corrective treatment in each of these cases is described. Likewise the application of therapy in psychiatric management of many cases during the war are included.

In presenting this excellent book the authors have avoided the use of many technical terms which make it of more value to those not familiar with the finer points in this important branch of medicine. The book should be of much value to physicians everywhere in dealing with the many types of psychiatric disturbances seen in civilian life.

Books Received

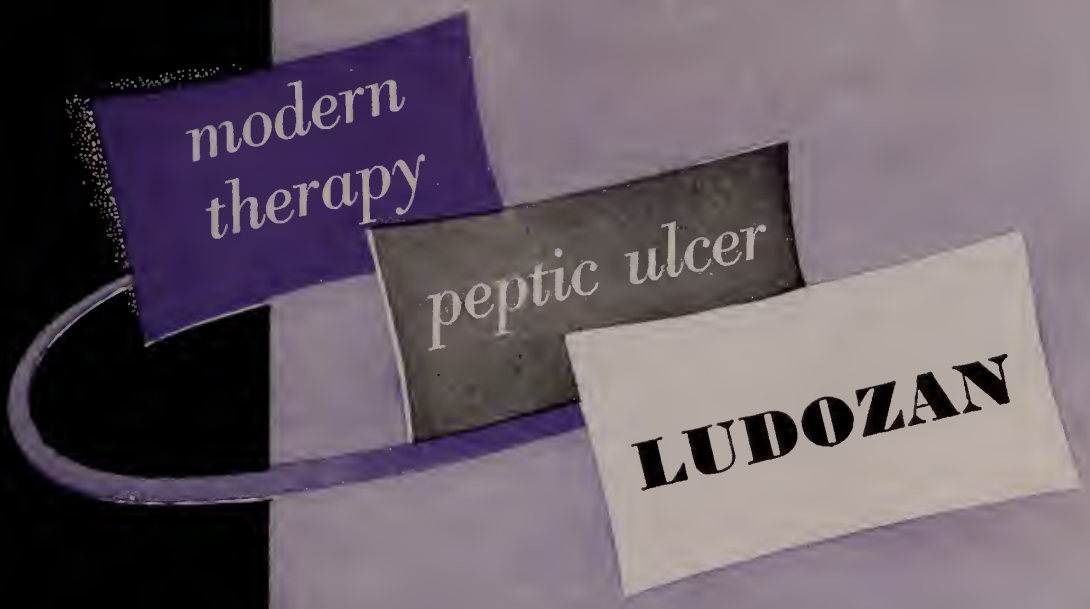
The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly murnish same promptly.

A Manual of Surgical Anatomy: Prepared under the auspices of the Committee on Surgery of the Division of Medical Sciences of the National Research Council, by Tom Jones and W. C. Shepard. 254 pages with 267 illustrations on 138 figures, 153 in colors. Philadelphia and London: W. B. Saunders Company, 1945. Price $3.00.

Essentials of Neuro-Psychiatry. A Textbook of Nervous and Mental Disorders. By David M. Olkon, S.B., A.M., M.D., Associate Professor of Psychiatry, College of Medicine, University of Illinois. Illustrated with 138 Engravings. Lea & Febiger, Philadelphia, 1945. Price $4.50.

Plaster of Paris Technique in the Treatment of Fractures and Other Injuries. By T. B. Quigley, Lieutenant Colonel, Medical Corps, Army of the United States; Instructor in Surgery; Harvard Medical School (in absentia); Junior Associate in Surgery, Peter Bent Brigham Hospital, Boston (in ab-

(*Continued on page* 74)



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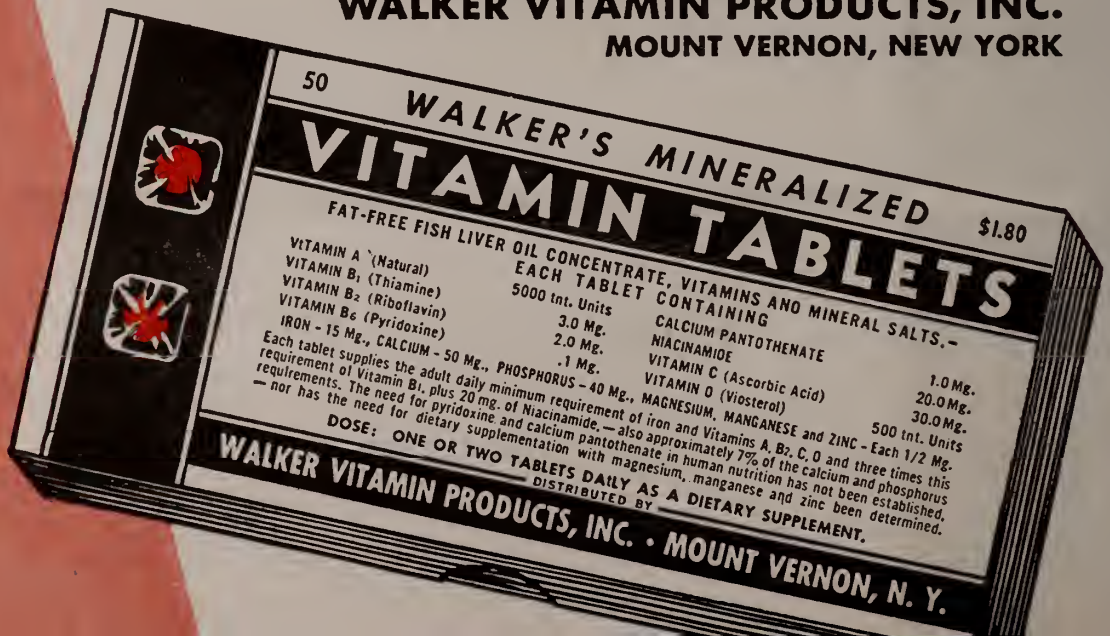


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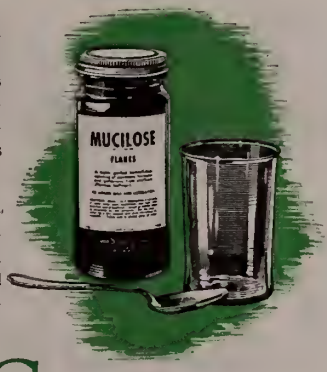
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INDICATED in the treatment of both spastic and atonic constipation, and as an adjunct to dietary measures for the control of constipation in aged, convalescent and pregnant patients... those with hemorrhoids, and with erratic dietary habits.



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BOOKS RECEIVED (Continued)

sentia). The Macmillan Company, New York, 1945. Price $3.50.

PATHOLOGY OF TROPICAL DISEASES: By J. E. Ash, Colonel, M.C., U.S.A., Director, Army Institute of Pathology, Army Medical Museum; and Sophie Spitz, M.D., C.S., A.U.S., Pathologist, Army Institute of Pathology, Army Medical Museum. 350 pages with 941 illustrations, 15 in color, on 257 plates. Philadelphia and London: W. B. Saunders Company, 1945. Price $8.00.

A TEXTBOOK OF SURGERY: By American Authors: Edited by Frederick Christopher, B.S., M.D., F.A.C.S., Associate Professor of Surgery, Northwestern University Medical School; Chief Surgeon, Evanston (Illinois) Hospital. Fourth Edition, Revised and Reset. 1548 pages with 1483 illustrations on 762 figures. Philadelphia and London: W. B. Saunders, 1945. Price $10.00.

PENICILLIN BY MOUTH IS EFFECTIVE IN GONORRHEA TREATMENT

Five San Francisco doctors believe that 50,000 units of penicillin administered by mouth every two hours for 10 doses may result in the cure of most patients with gonorrhea, according to the October 6 issue of *The Journal of the American Medical Association.*

Oral penicillin, administered in capsule form, was the treatment used on 77 patients, 53 of whom had acute gonorrhea. Of this latter group 38, or 72 per cent, were cured.

Many experiments were tried to find a coating for penicillin which would protect it from stomach acids. It has been found in the past that these acids interfere with the absorption of the drug in the blood. The doctors succeeded in finding an alkaline coating material which gave highly favorable results from the standpoint of absorption.

If tuberculosis is to be eradicated, it is essential that the rate at which infectious cases develop in the population be maintained permanently below the rate at which infectious cases are isolated and prevented from spreading the disease. Furthermore, the greater the disparity in the two rates, the more quickly will this eradication be achieved. These fundamental principles, pointed out by Frost, must be constantly borne in mind in the planning and execution of every tuberculosis control program in every community, if success is to be attained. Herman E. Hilleboe, M.D. & Arthur W. Newitt, M.D., Journal-Lancet, April, 1945.

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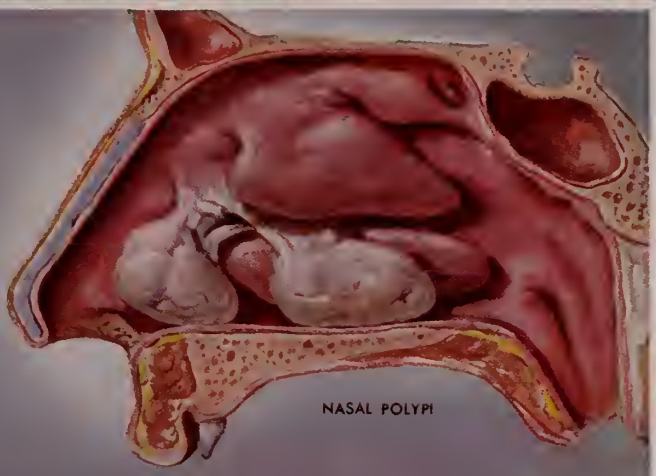
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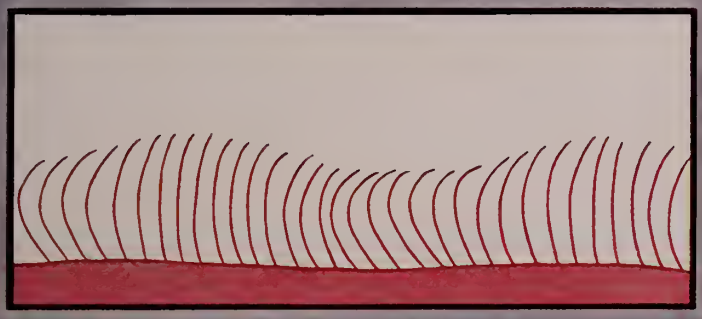


ASPECT IN HAY FEVER

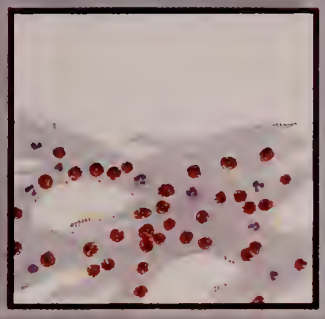


NASAL POLYPI

CILIARY BEAT (schematically)

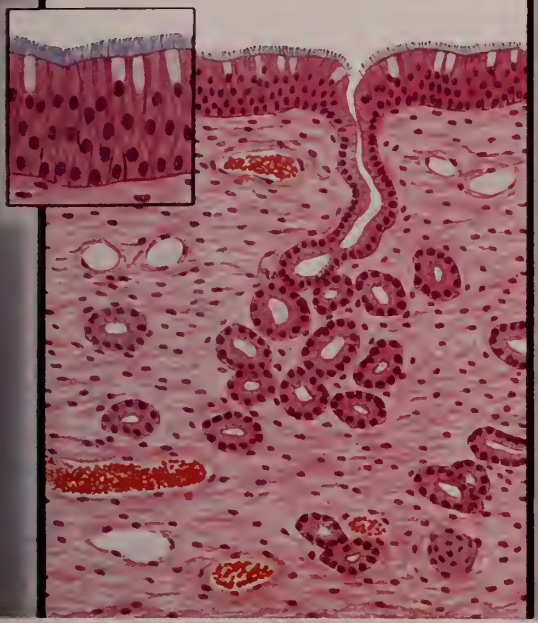


ALLERGIC RHINITIS

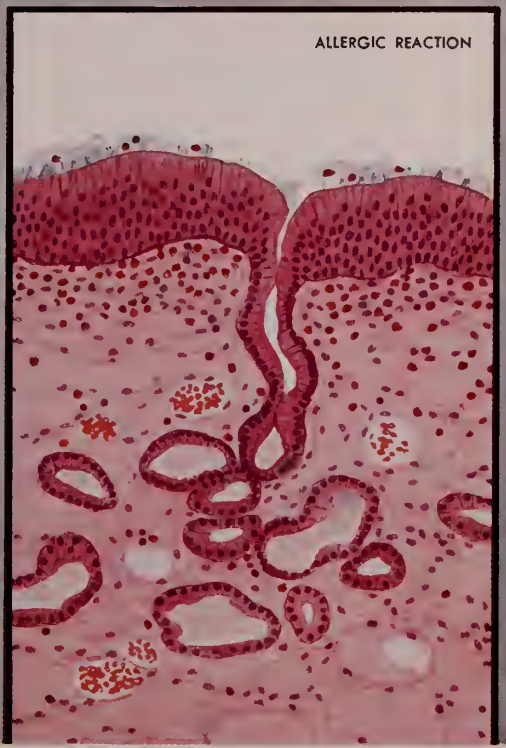


NASAL MUCOUS MEMBRANE

NORMAL



ALLERGIC REACTION



ACUTE AND CHRONIC NASAL ALLERGY

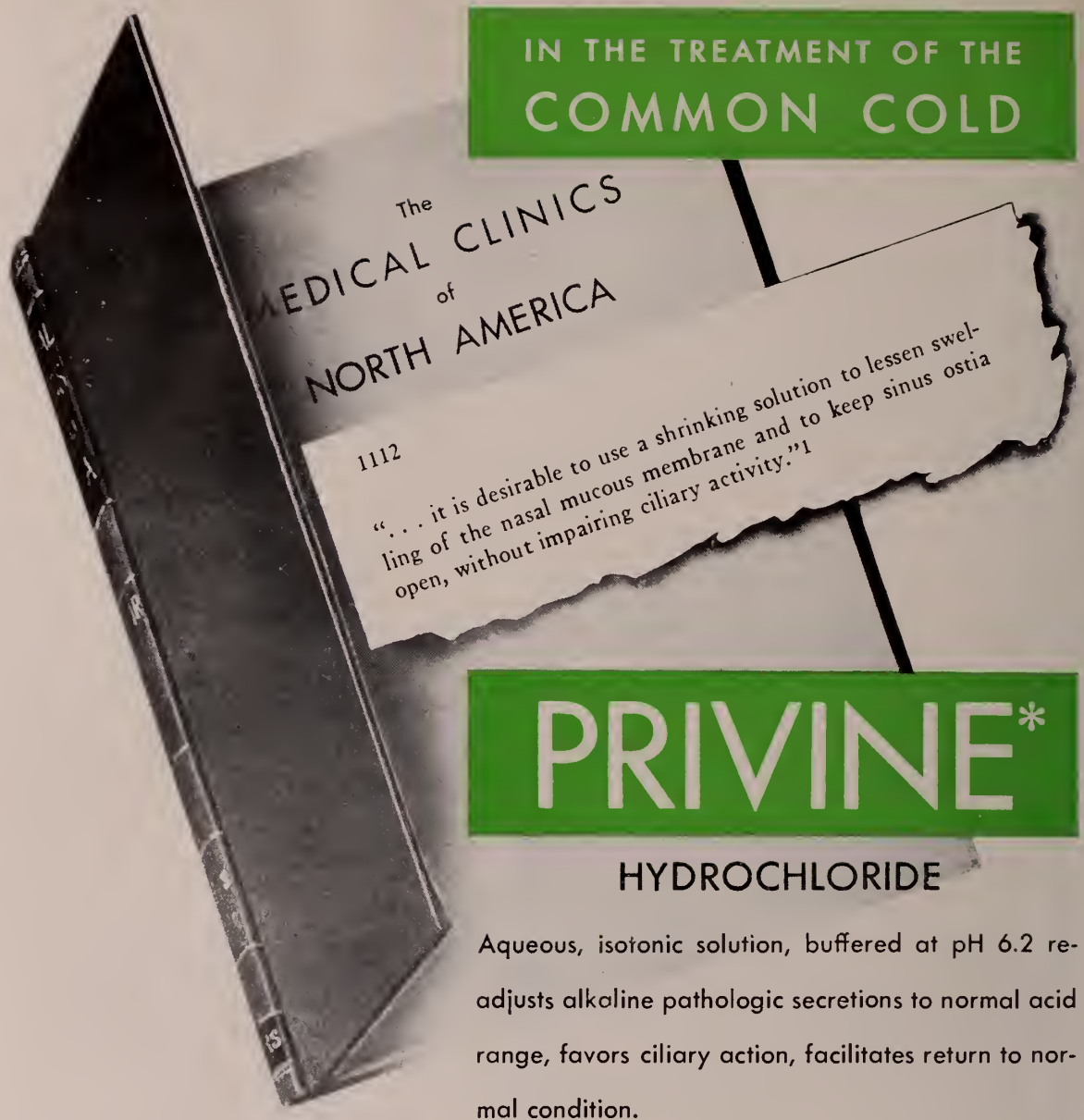
. . . from the Portfolio, "Major Pathology of the Nose and Accessory Sinuses."

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1. Medicol Clinics of North Americo, 1108, Sept. 1944.

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Pneumonia, once a frequently fatal disease, causing about 96,500 deaths in the United States annually, is gradually retreating before the advance of modern medicine.

The medical profession now recognizes oral penicillin as a convenient and effective method in the treatment of the disease.

Three articles covering the administration of penicillin by mouth for pneumonia and other bacterial diseases are published in the September 29 issue of *The Journal of the American Medical Association.* All three articles agree that oral penicillin is effective in treating pneumonia.

With the advent of this new, convenient method of treating pneumonia, physicians recall their experiences in treating the disease 20, and even 10 years ago. At that time there was no successful specific treatment for pneumonia. Many hospitals found that more than one fourth of all pneumonia patients died. In some types of cases a 50 per cent death rate was a common occurrence.

Then with the development of the sulfonamides, pneumonia deaths began to decline sharply. Along

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came penicillin, and treatment with both of these drugs cut the mortality to a minimum. During the war, for example, the pneumonia death rate in the Army was only 0.7 per cent, compared with 28 per cent during World War I.

Seven Army doctors reported recently that in pneumonia, the response from both agents was almost identical; the only difference being a more abrupt fall in temperature and fewer instances of spreading infection with penicillin.

While oral penicillin has been tried experimentally for some time, the three *Journal* articles explain various technics used, the success accomplished, and the advantages over the regular method of administering penicillin by injection.

One article was prepared by four New York physicians: Paul A. Bunn, Walsh McDermott, Susan J. Hadley and Anne C. Carter, all from the Departments of Medicine, Cornell University Medical College and the New York Hospital.

They treated 45 pneumonia patients with penicillin by mouth. The patients, ranging in age from 15 to 89 years, were treated in New York Hospital and in the Second Medical (Cornell) Division of Bellevue Hospital, New York. Out of the 45 treated, there was only one death—a 50 year old man, an alcoholic addict, who had been found in bed at home by neighbors with an acute illlness of unknown duration.

(*Continued on page* 80)

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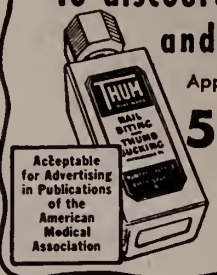
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ORAL PENICILLIN (Continued)

In their series of tests, the physicians administered penicillin in capsule form.

Earlier studies on the absorption of the drug revealed that most of an orally administered dose was probably destroyed by the acid in the stomach. The research group solved this problem by suspending the penicillin in corn or cotton seed oil, enclosed for convenience in a quick-dissolving gelatin capsule. By suspending the penicillin in oil, the drug was protected from stomach acidity.

"Although relatively huge amounts of penicillin were used at the beginning of the study," the article said, "the patients in the latter half of the series received 750,000 units of penicillin on the first day and 400,000 to 600,000 units on the subsequent days of treatment."

In the majority of patients there was an abrupt fall in temperature soon after oral penicillin was started. It requires from 30 to 60 minutes before the peak concentration of penicillin in the blood is reached. Such a short delay is not considered significant in the treatment of most pneumonia patients. One salient point of the study is that four or five times as much penicillin must be given by mouth to reach the same blood level as when the drug is given by injection.

The four doctors concluded that in order to diminish the possibility of relapse, treatment should be pro-

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longed for seven or more days, depending on the duration and the severity of infection.

In the second article, three pediatricians—Sidney Ross, Frederic Gerard Burke and P. A. McLendon—from George Washington University, Washington, D. C., reported the effectiveness of oral penicillin administered to 10 children with gonorrhea, two with pneumonia and two with cellulitis, an inflammation of the soft tissues underlying the skin. There was prompt recovery in all cases.

The doctors found that a 100,000 unit penicillin capsule every three hours provided effective concentration of the drug. They recommended several agents for neutralizing the acid in the stomach before the penicillin treatment was started.

In the third article, prepared by Drs. Maxwell Finland, Manson Meads and Edwin M. Ory of the Department of Medicine, Harvard Medical School, the investigators found that the greatest benefit could be obtained when the penicillin was taken on an empty stomach. When the penicillin was taken a half hour before breakfast, absorption in the blood stream was "good and regular." When taken after a meal, the penicillin levels were "irregular and unpredictable."

The article reported that a dose of 90,000 units of penicillin given by mouth before breakfast provided penicillin levels comparable with those obtained from 15,000 or 20,000 units given by injection into the muscle. The oral doses are given every two hours.

"The results of preliminary clinical trials in gonorrhea and in pneumonia," the doctors wrote, "suggest that oral penicillin therapy is feasible in these infections."

The myth that tuebrculosis is nearing the point of being conquered has received two rude shocks of late. The first is the discovery of tens of thousands of unsuspected cases through mass X-ray procedures. The second is autopsy proof that the infection rate has not lessened proportionately to the decline in mortality. Eradication of the tubercle bacillus lies far ahead. Nevertheless it can and must be done. Kendall Emerson, M.D., Ed. NTA Bulletin, Sept., 1945.

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The first group of Senior Cadet Nurses to complete the special Orthopaedic Nursing Course at the University of Illinois Orthopaedic Surgical Institute received certificates Oct. 27.

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The course was given in the Orthopaedic Surgical Institute of the University's Research and Educational Hospitals. The Institute is at 905 South Wolcott Street.

Thirty-seven completed the course, but 12 who have left the campus will be unable to attend the ceremony.

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That the medical profession has recognized the importance of this contribution is indicated by the fact that cereal is now routinely included in the infant's diet as early as the third or fourth month instead of at the sixth to twelfth month as was the custom only a decade or two ago.

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During the last twelve years, these products have been used in a great deal of clinical investigation of various aspects of nutrition, which have been reported in the scientific literature.

Many physicians recognize the pioneer efforts on the part of Mead Johnson & Company by specifying Mead's Cereal and PABLUM—and also the new Pablum-like oatmeal cereal known as PABENA.

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The ILLINOIS Medical Journal

VOL. 88 NO. 6

December, 1945

In This Issue

Compound Fractures

Medical Care For Veterans

Thrombosis of the Deep Veins of the Lower Extremities

(See page 35 for complete Table of Contents)

OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY

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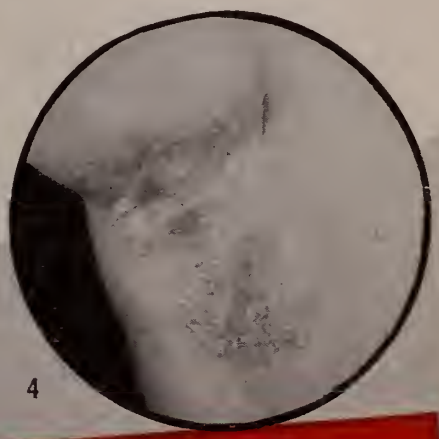
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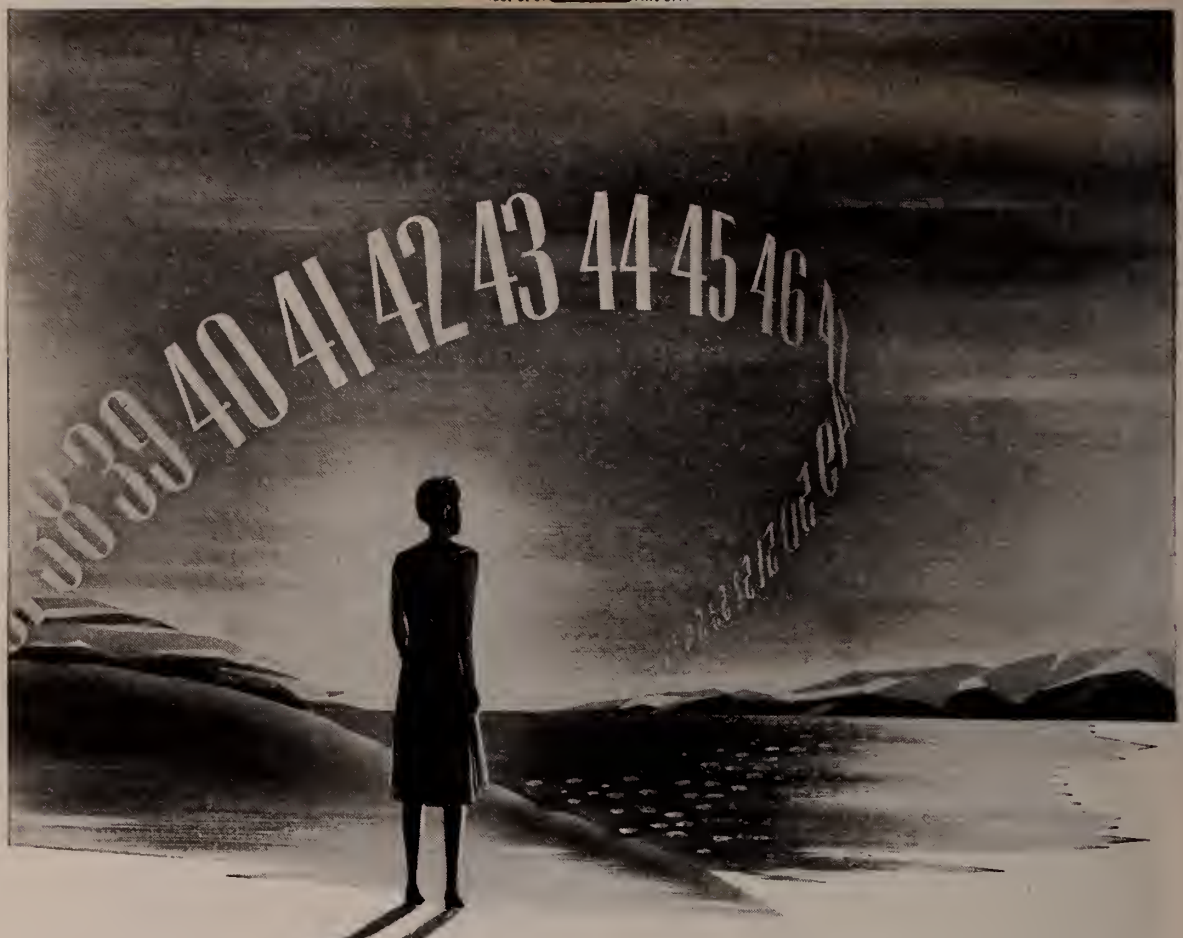
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White's MULTI-BETA LIQUID

is specifically formulated to correct these inadequacies, providing—in drop-dosage form—thiamine, riboflavin and nicotinic acid, in amounts proportionate to their insufficiency in the average diet of early infancy.

Five or more drops daily assure a generous supply of all clinically important B vitamins during the critical months of early life.

Supplied in bottles (with suitable droppers) of 10 cc., 25 cc. and 50 cc.



Ethically promoted. Not advertised to the laity.

PHARMACEUTICAL White MANUFACTURERS
LABORATORIES, INC.
NEWARK 2, N. J.



Third Degree

In severe thermal burns, when protein needs far exceed the limits of dietary toleration, Parenamine provides extra-dietary amino acids to restore and maintain positive nitrogen balance and correct hypoproteinemia*

Parenamine

AMINO ACIDS STEARNS, PARENTERAL

For protein deficiency

PARENAMINE is a sterile 15 per cent solution of amino acids containing all known to be essential for humans, derived by acid hydrolysis from casein, fortified with pure *dl*-tryptophane.

INDICATED in conditions of restricted intake, faulty absorption, increased need or excessive loss of proteins such as in preoperative and postoperative management, extensive burns, delayed healing, gastro-intestinal disorders, fevers, et cetera.



ADMINISTRATION may be intravenous, intrasternal or subcutaneous.

SUPPLIED as 15 per cent sterile solution in 100 cc. rubber-capped bottles.

**Reprints and complete clinical data will gladly be sent on request.*

Frederick Stearns & Company
Division

DETROIT 31, MICHIGAN

NEW YORK KANSAS CITY SAN FRANCISCO WINDSOR, ONTARIO SYDNEY, AUSTRALIA AUCKLAND, NEW ZEALAND

Trade-Mark Parenamine Reg. U. S. Pat. Off.



Expanding ——

The rapidly increasing demand for Pitman-Moore Biologicals has compelled us to launch an extensive new building program.

With the completion of a large addition to the main building of our Biological Laboratories, increased capacity has been provided for vaccine production, serum processing and control testing.

Construction has also just begun on a new building to house laboratory-test animals, including thousands of additional white mice, hamsters, guinea pigs, dogs, cats and other animals essential to safeguarding the potency, purity and safety of finished products.

Pitman-Moore look forward to an ever expanding program of service to the medical profession through the medium of the Biological Laboratories at Zionsville, Indiana, as well as the Pharmaceutical and Research Laboratories at Indianapolis.

PITMAN-MOORE COMPANY

PHARMACEUTICAL AND BIOLOGICAL CHEMISTS

Division of Allied Laboratories, Inc., · Indianapolis 6, Indiana



Illustrated is the sulfathiazole-frosted pharynx of patient A.K., *two hours* after Paredrine-Sulfathiazole Suspension had been instilled intranasally.

WHY SUCH RAPID RELIEF

TO OBTAIN BEST RESULTS . . . the sore throat patient should not eat or drink fluids for one or two hours after instillation of Paredrine-Sulfathiazole Suspension. He should also make every effort to reduce nose-blowing and throat-clearing to a minimum.

Smith, Kline & French Laboratories, Philadelphia, Pa.

IN SORE THROAT ?

Sulfathiazole is particularly effective against the hemolytic streptococcus, which apparently causes the vast majority of sore throats.

There are two other important reasons why Paredrine-Sulfathiazole Suspension—when administered intranasally—is so successful in the treatment of acute nasopharyngitis:

1 Part of the Suspension remains beneath the middle and superior turbinates—and, mixing with sinus drip, retards the proliferation of bacteria before they reach the nasopharynx and intensify the infection.

2 Part of the Suspension drifts downward over the nasopharynx, forming a fine frosting on the nasopharyngeal mucosa. This thin blanket not only keeps producing a bacteriostatic solution at the site of infection, but also appears to provide marked surface analgesia.

PAREDRINE-SULFATHIAZOLE SUSPENSION

vasoconstriction in minutes

bacteriostasis for hours



ACCEPTED
AMERICAN MEDICAL ASSN.
Council on Pharmacy and Chemistry

PRIVINE*
HYDROCHLORIDE
ACCEPTED

PRIVINE Hydrochloride (Naphazoline) has been accepted for inclusion in New and Non-Official Remedies of the Council on Pharmacy and Chemistry of the American Medical Association. The following dosages are recommended: 0.1% for adults — 0.05% for adults and children.

*Trade Mark Reg. U. S. Pat. Off.

CIBA PHARMACEUTICAL PRODUCTS, INC.
SUMMIT, NEW JERSEY
IN CANADA, CIBA COMPANY LIMITED, MONTREAL





HIGHLY EFFECTIVE

PROLONGED ACTION

ISOTONIC pH 6.2 BUFFERED

ONLY 3 DROPS

of PRIVINE in each nostril are needed for prompt and prolonged vasoconstriction.

PRIVINE usually provides symptomatic relief from nasal congestion for 2 to 6 hours without reapplication.

PRIVINE is prepared in isotonic solutions, strongly buffered in the same pH as the delicate nasal mucous membranes.

a Ciba Product

PRIVINE

Announcing

the attainment of another objective
in the field of nutrition



The SQUIBB THERAPEUTIC FORMULA Vitamin Capsule is a *truly* therapeutic mixed vitamin preparation. It is founded on the concept that therapeutic requirements *cannot* be met by any simple multiple of present maintenance dosages.

Squibb Therapeutic Formula, based on practical clinical experience, provides the following dosages of therapeutic magnitude in a single capsule:

Vitamin A	25,000 units	Riboflavin	5 mg.
Vitamin D	1,000 units	Niacinamide	150 mg.
Thiamine HCl	5 mg.	Ascorbic Acid	150 mg.

SQUIBB *Therapeutic Formula*
VITAMIN CAPSULES

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

WHEN THE NATURAL PRODUCTION OF MALE SEX HORMONE

DIMINISHES with declining gonadal function, replacement therapy with ORETON will offset the androgenic inadequacy.

ORETON

supplies the needed male sex hormone for maintenance of normal physical and emotional balance in the male climacteric and in other androgen deficiency states. When normal sexual growth is retarded in the formative years, proper development of the male genitalia and secondary sex characteristics may be achieved with ORETON.

PACKAGING. ORETON (testosterone propionate in oil) for intramuscular injection. Ampules of 1 cc. containing 5, 10, 25 mg. Boxes of 3, 6 and 50 ampules.

TRADE MARK ORETON—REG. U. S. PAT. OFF.

SCHERING

Schering CORPORATION • BLOOMFIELD, N. J.



"Streamline" TO CREOSOTE THERAPY

Rx Calcreose

PALATABLE • WELL TOLERATED • THERAPEUTICALLY EFFECTIVE

The development of CALCREOSE (Maltbie) has, indeed, "smoothed the rough spots" in creosote therapy so frequently provocative heretofore of nausea and distress. • Moreover, CALCREOSE (calcium creosotate) exerts bactericidal and bacteriostatic action up to *three times as great* as that of creosote. • Thus, in providing all the well-known benefits of creosote in a *pleasant* and *palatable* form, CALCREOSE proves highly effective in many bronchial and respiratory affections . . . lessening cough, diminishing expectoration, reducing its purulency and deodorizing sputum. Also it tends to stimulate the appetite and improve the patient's general condition.

AVAILABLE: As tablets (4 gr.) in bottles of 100, 500, and 1000. COMPOUND SYRUP CALCREOSE in pint or gallon bottles.



Calcreose

THE MALTBIE CHEMICAL COMPANY • NEWARK, NEW JERSEY



"my doctor's nose drops don't sting!"

Fussy children with stuffy noses from coryza, sinusitis, or allergic rhinitis are more apt to cooperate when the pediatrician prescribes 'Vaporole' brand Ephedrine Isotonic Solution (Aqueous) to relieve nasal congestion. In its non-oily vehicle of modified Locke's solution, 'Vaporole' Ephedrine Isotonic Solution affords prompt, long-lasting shrinkage of nasal mucosa without inhibiting ciliary action. Because it does not sting little noses it promotes confidence between the physician and his most critical group of young patients.

'VAPOROLE' Reg. Trademark.

'VAPOROLE' EPHEDRINE ISOTONIC SOLUTION (Aqueous) containing 1 percent ephedrine in an isotonic solution of sodium, potassium and calcium chlorides and dextrose (modified Locke's solution) . . . Bottles of 1 fluidounce and 1 pint.

BURROUGHS WELLCOME & CO (U.S.A.) INC., 9 & 11 EAST 41ST STREET, NEW YORK 17, N.Y.



AT THE MENOPAUSE...

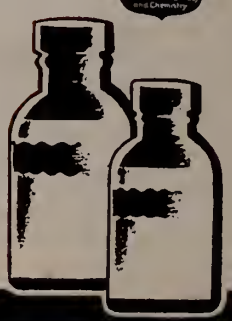
That Feeling of Well-Being

Patients on "Premarin" therapy usually experience a general feeling of well-being in addition to relief of symptoms; this is confirmed by most of the many clinical reports. Rendering the patient symptom-free is, of course, the prime consideration of treatment; many physicians, however, feel that the restoration of a brighter mental outlook is also an important consideration when instituting therapy. "Premarin" will be found to exhibit the desirable characteristics of both the natural estrogens and the synthetic substances. Although highly potent, "Premarin" is derived exclusively from natural sources; it is exceptionally well tolerated, and unpleasant side effects are seldom noted.

HIGHLY POTENT
ORALLY ACTIVE
NATURALLY OCCURRING
ESSENTIALLY SAFE
WATER SOLUBLE
WELL TOLERATED

"Premarin"
Reg. U. S. Pat. Off.
TABLETS
CONJUGATED ESTROGENS (equine)

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry



Available in 2 potencies:

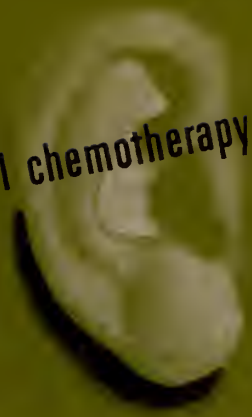
No. 866 (the YELLOW tablet), in bottles of 20, 100 and 1,000 tablets
No. 867 HALF-STRENGTH (the RED tablet), in bottles of 100 and 1,000 tablets

Ayerst

AYERST, McKENNA & HARRISON LTD.,
22 E. 40th St., New York 16, N. Y.

unusually effective topical chemotherapy in acute *and* chronic

EAR INFECTIONS



Effectively antibacterial, analgesic and antipruritic — hypertonic but non-irritating — White's Otomide provides a *most effective* topical chemotherapy for *both* acute *and* chronic bacterial ear infections.

FORMULA:	SULFANILAMIDE	5%
	CARBAMIDE (Urea)	10%
	CHLOROBUTANOL	3%
	GLYCERIN (high sp. gr.)..	q.s.

INDICATIONS: Local prevention and treatment of acute and chronic bacterial infections of the middle ear and external auditory canal.

ADVANTAGES: *Effectively bacteriostatic* even in the presence of pus. Carbamide enhances antibacterial activity, inhibits sulfonamide-antagonists in purulent exudates. *Analgesic, antipruritic* — chlorobutanol, therapeutically compatible with sulfonamides. effects gratifying relief of pain.

Prompt cessation of discharge and remission of foul odor in purulent otorrhea.



Supplied in one-half fluid ounce (15 cc.) dropper bottles. Dispensed only upon prescription. **White Laboratories, Inc., Pharmaceutical Manufacturers, Newark 7, N. J.**

White's OTOMIDE

Medications of Choice FOR THE SPECIFIC INVOLVEMENT



Auralgan

in ACUTE OTITIS MEDIA

Symptoms

Pain, fever, edema, leucocytosis, sense of fullness and impaired hearing.

Treatment

Relief of pain and inflammation—*Auralgan.*

Action

Decongestant, analgesic, bacteriostatic.

Scientific data and reprints of clinical studies reporting upon the use of Otosmosan available on request.



Otosmosan

in CHRONIC SUPPURATIVE OTITIS MEDIA

Symptoms

Persistent discharge, often foul smelling, usually no toxemia, no pain, no fever.

Treatment

Otosmosan.

Formula

Sulfathiazole carbamide 20% in glycerol (Doho).

Action

Deodorizes the discharge, liquifies unhealthy granulations, bacteriostatic, permits normal epithelialization.

Complimentary quantities for clinical trial

THE DOHO CHEMICAL CORPORATION

New York 13, N. Y. • Montreal • London

for "a potent estrogen effect *"with greater economy"*

By prescribing Lynoral, the physician provides his menopausal patients with ethinyl estradiol which has "a potent estrogen effect . . . with greater economy" (1). It is "exceedingly active by mouth" (2) and produces a "definite therapeutic response" (1) in a dose as low as *one-fiftieth of a milligram!* Small wonder that Lynoral which induces gratifying menopausal comfort at such a surprisingly low cost has rapidly developed into the preferred estrogen for oral administration. Lynoral is available in 0.05-mg tablets (scored for easy dosage adjustment), bottles of 30, 60, and 250 . . . ROCHE-ORGANON, INC., Roche Park, Nutley 10, New Jersey.



Lynoral

'ROCHE-ORGANON'

(1) F. E. Harding, *Am. J. Obst. & Gynec.*, 48:181, 1944. (2) W. M. Allen, *South. M. J.*, 37:270, 1944.



to alleviate prolonged postpartum depression



A dreary sense of futility, emptiness and pessimism sometimes afflicts the postpartum patient and may prolong the period of recovery.

When the characteristic syndrome of true depression follows childbirth, the administration of Benzedrine Sulfate is often of dramatic value. Obviously, it should not be used for the casual case of low spirits or normal physiological depression as distinguished from a true and prolonged mental depression.

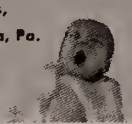




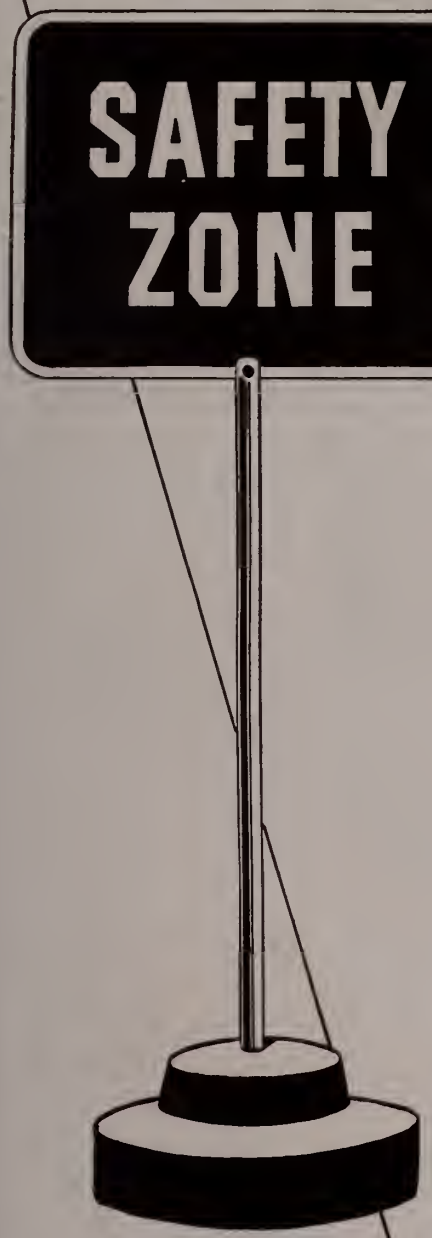


benzedrine sulfate
(racemic amphetamine sulfate, S.K.F.)
tablets and elixir

Smith, Kline & French Laboratories, Philadelphia, Pa.



Paul Rand



in Sulfonamide therapy

The safety zone in sulfonamide therapy—urinary pH of 7.5 to 8.0, is attained simply and pleasantly with 'Alka-Zane'* Alkaline Effervescent Compound.

Affording prolonged urinary alkalization for optimal solubility of sulfonamides and their acetyl derivatives, 'Alka-Zane' Alkaline Effervescent Compound simultaneously provides increased liquid intake to assure adequate diuresis. Crystalluria, the most common single complication of sulfonamide therapy, is thus obviated by one simple measure

In solution, each heaping teaspoonful of 'Alka-Zane' Alkaline Effervescent Compound supplies:

Sodium citrate	41 grains (2.70 Gm.)
Sodium bicarbonate	25.30 grains (1.60 Gm.)
Calcium phosphate	3.80 grains (0.25 Gm.)
Magnesium phasphate	3.80 grains (0.25 Gm.)
Calcium glycerophasphate	1.80 grains (0.10 Gm.)

'Alka-Zane' Alkaline Effervescent Compound may be combined with water, milk or fruit juices to make a thoroughly palatable and refreshing drink. *Supplied* as white granules, in bottles of 1½ oz., 4 oz. and 8 oz.

William R. Warner & Co., Inc., 113 West 18th Street, New York 11, N. Y.

'alka-zane'

*Trademark Reg. U. S. Pat. Off.



Easily calculated... quickly prepared. 1 fl. oz. Biolac to 1½ fl. oz. water per pound of body weight.

"you sure sound good to me, mister"...

—A typical compliment to "Biolac Babies"—and, at the same time, a reflection of the physician's good judgment.

The soft-curd characteristics of Biolac assure ease of digestion. Adjusted milk fat content facilitates digestion and assimilation, with greater freedom from fat upsets; ample lactose assures soft, natural stool formation; and a high protein level contributes to optimal growth and health.

Since Biolac supplies adequate potencies of Vitamins A, B_1, B_2, and D, as well as iron, the need for time-consuming calculations of extra formula ingredients is eliminated. Indeed, Biolac (supplemented with vitamin C) provides *completely* for the nutritional requirements of the infant partially or entirely deprived of human milk.

BORDEN'S PRESCRIPTION PRODUCTS DIVISION
350 MADISON AVENUE NEW YORK 17, N. Y.

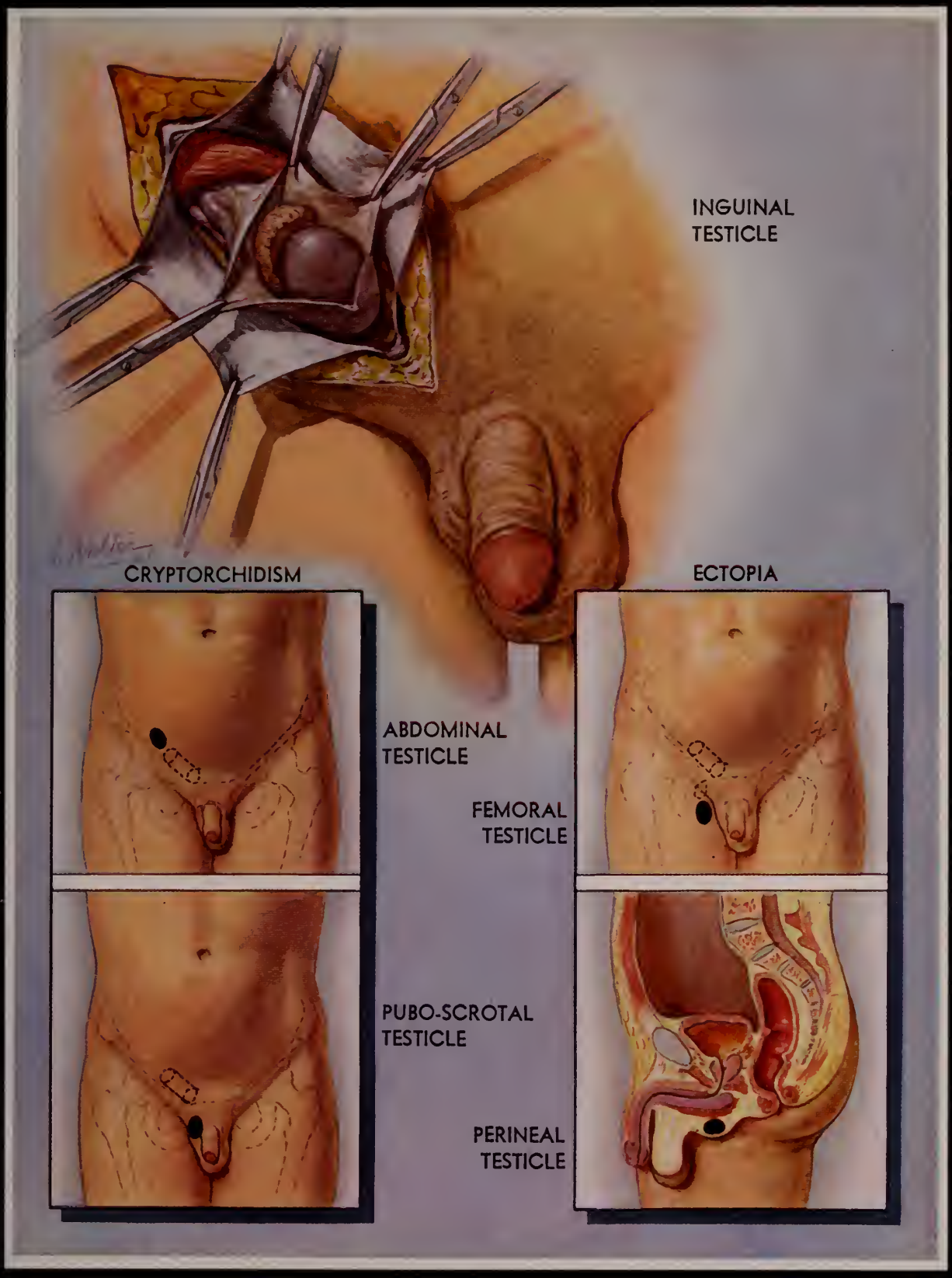


Biolac

"BABY TALK" FOR A GOOD SQUARE MEAL

Biolac is a liquid modified milk, prepared from whole and skim milk, with added lactose, and fortified with vitamin B_1, concentrate of vitamins A and D from cod liver oil, and iron. Evaporated, homogenized, and sterilized. Vitamin C supplementation only is necessary. Biolac is available in 13 fl. oz. cans at all drug stores.

ACCEPTED AMERICAN MEDICAL ASSN



MALPOSITION OF THE TESTICLE

. . . from the Portfolio, "Major Pathology of the Testicle and Prostate."

Pioneers in reseorch leoding to the development of phormoceuticols of outstonding merit, Ciba hos olso pioneered in publishing over 140 fine plotes of normal ond pathological anotomy in the post five years, such os the one reproduced here. Becouse many of the series ore out of print, the most popular anes are being reprinted here by request. And many more plates are plonned for the neor future. This is but onother service that Cibo is proud to render to the medicol profession.

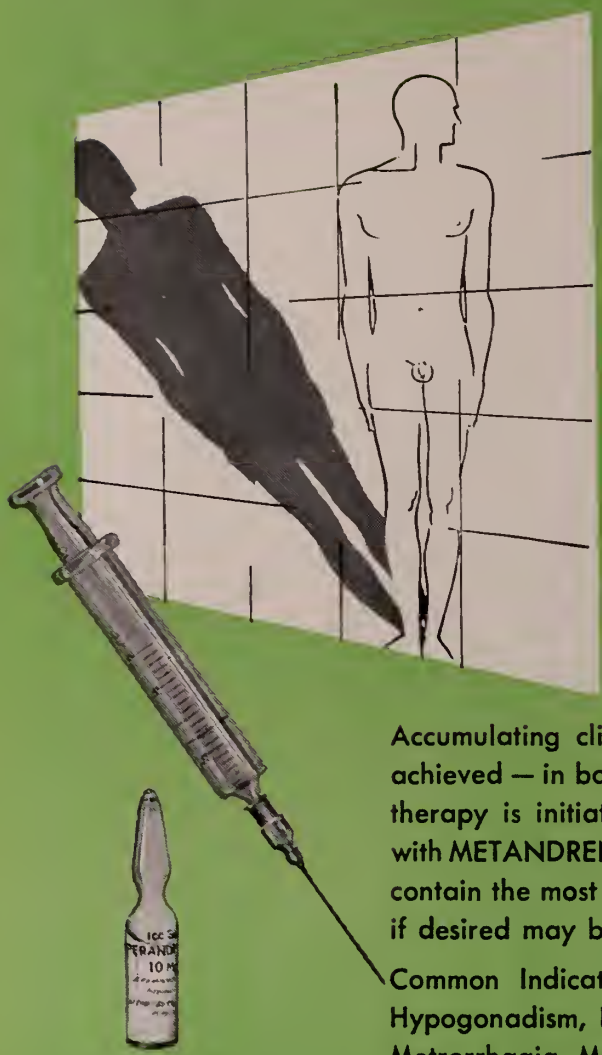
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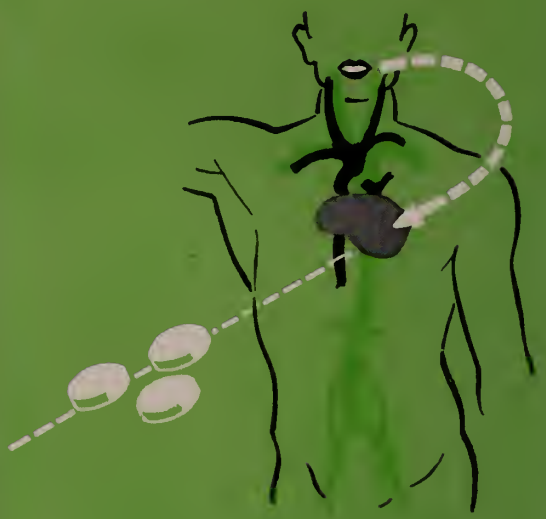
Pharmaceutical Products, Inc.
SUMMIT, NEW JERSEY
IN CANADA
CIBA COMPANY LIMITED, MONTREAL

TOMORROW'S MEDICINES FROM TODAY'S RESEARCH

COMBINED ANDROGENIC THERAPY

(PER ORAL AND PARENTERAL)





Accumulating clinical reports show that prompt results are achieved — in both the male and female — when androgenic therapy is initiated with PERANDREN*, and then followed with METANDREN* Tablets. Both intramuscular and oral forms contain the most effective androgenic substances known, and if desired may be used interchangeably in most indications.

Common Indications for Androgenic Therapy: Impotence, Hypogonadism, Eunuchism, Angina pectoris — Menorrhagia, Metrorrhagia, Menopause, Dysmenorrhea.

PERANDREN (testosterone propionate) and METANDREN (methyl-testosterone) have all the advantages of the natural testicular hormone, testosterone.

PERANDREN AND METANDREN

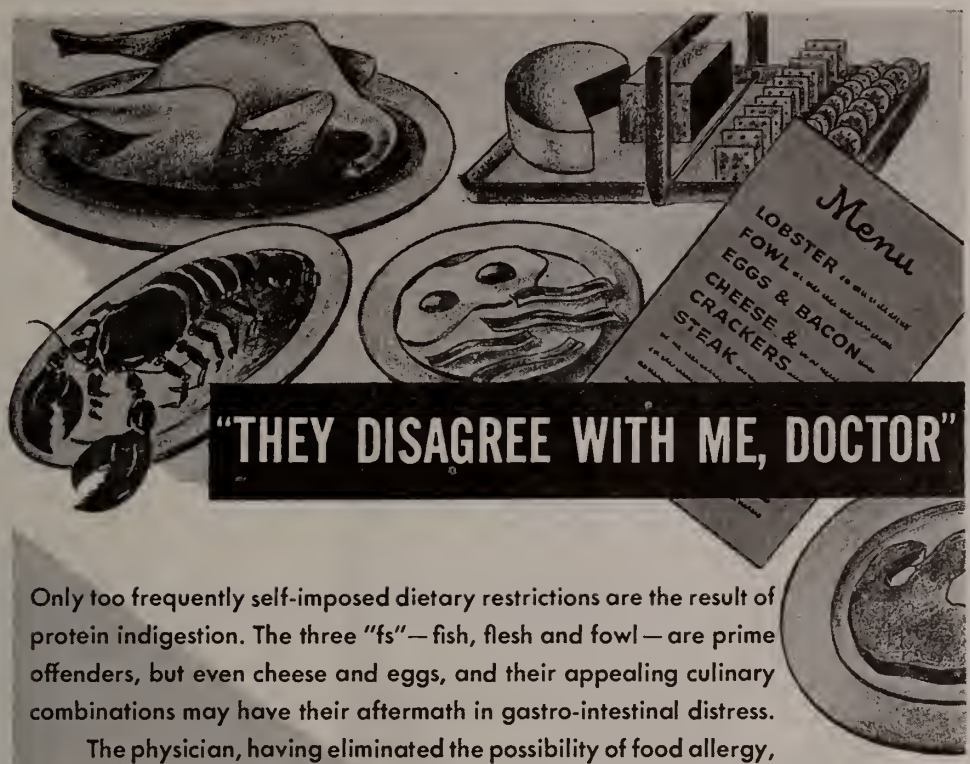
*Trade Marks Reg. U. S. Pat. Off.

PERANDREN: in ampuls of 1 cc. containing 5 mg., 10 mg., and 25 mg.

METANDREN: in tablets of 10 mg., scored.

a Ciba Product

CIBA PHARMACEUTICAL PRODUCTS, INC. • SUMMIT, NEW JERSEY
IN CANADA, CIBA COMPANY LIMITED, MONTREAL



"THEY DISAGREE WITH ME, DOCTOR"

Only too frequently self-imposed dietary restrictions are the result of protein indigestion. The three "fs"—fish, flesh and fowl—are prime offenders, but even cheese and eggs, and their appealing culinary combinations may have their aftermath in gastro-intestinal distress.

The physician, having eliminated the possibility of food allergy, thinks naturally of insufficiency of digestive enzymes as an etiological factor in such conditions. Supplementation of proteolytic enzymes with PEPTENZYME DIGESTANT TABLETS, which contain pepsin, desiccated duodenum, and desiccated pancreas, is a rational therapeutic procedure in the prophylaxis and treatment of protein indigestion. Their use not infrequently permits the patient wider indulgence in dietary preference.

Peptenzyme Digestant Tablets are also of assistance in digestive disturbances resulting from high protein diets, such as those recommended in obesity, anemia, nutritional edema, and in the modern treatment of nephritis and nephrosis.

FORMULA: Each tablet contains: Pepsin, N.F. 1 grain; Pancreas, desiccated ½ grain; Duodenum, desiccated ⅕ grain. Pleasantly flavored.

DOSAGE: 2 to 8 tablets with meals as directed by physician.

PACKAGING: In bottles of 100, 500 and 1,000.

REED & CARNRICK

JERSEY CITY 6, NEW JERSEY
TORONTO, ONT., CANADA

PEPTENZYME DIGESTANT · TABLETS ·

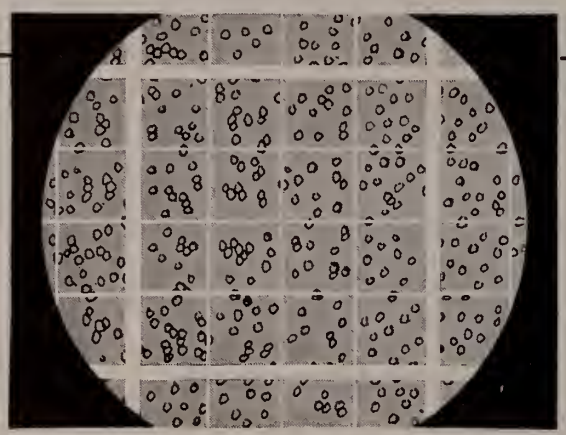
PEPTENZYME DIGESTANT POWDER, similar in composition to Peptenzyme Digestant Tablets, is especially indicated for use in prescriptions.

DOSAGE: 10 to 40 grains with meals, as directed by physician.

PACKAGING: In bottles of 1 and 8 oz.

Number 3 of a Series

IN ANEMIA OF CHRONIC BLOOD LOSS





In the management of chronic blood loss, therapy designed to support red cell and hemoglobin formation is essential. Iron must be supplied to correct hypochromia; liver and the B vitamins bolster an overworked bone marrow in the production of red cells. The combination is more effective than iron alone.

HEPATINIC

presents iron in readily assimilable ferrous form, together with Crude (Unfractionated) Liver Concentrate and Vitamin B Complex.

Crude (Unfractionated) Liver Concentrate is prepared so that it retains the erythropoietic and nutritional principles of whole liver, which are lost in the highly refined concentrates. Furthermore, it is subjected to enzymatic digestion to provide maximum assimilation and prompt therapeutic response.

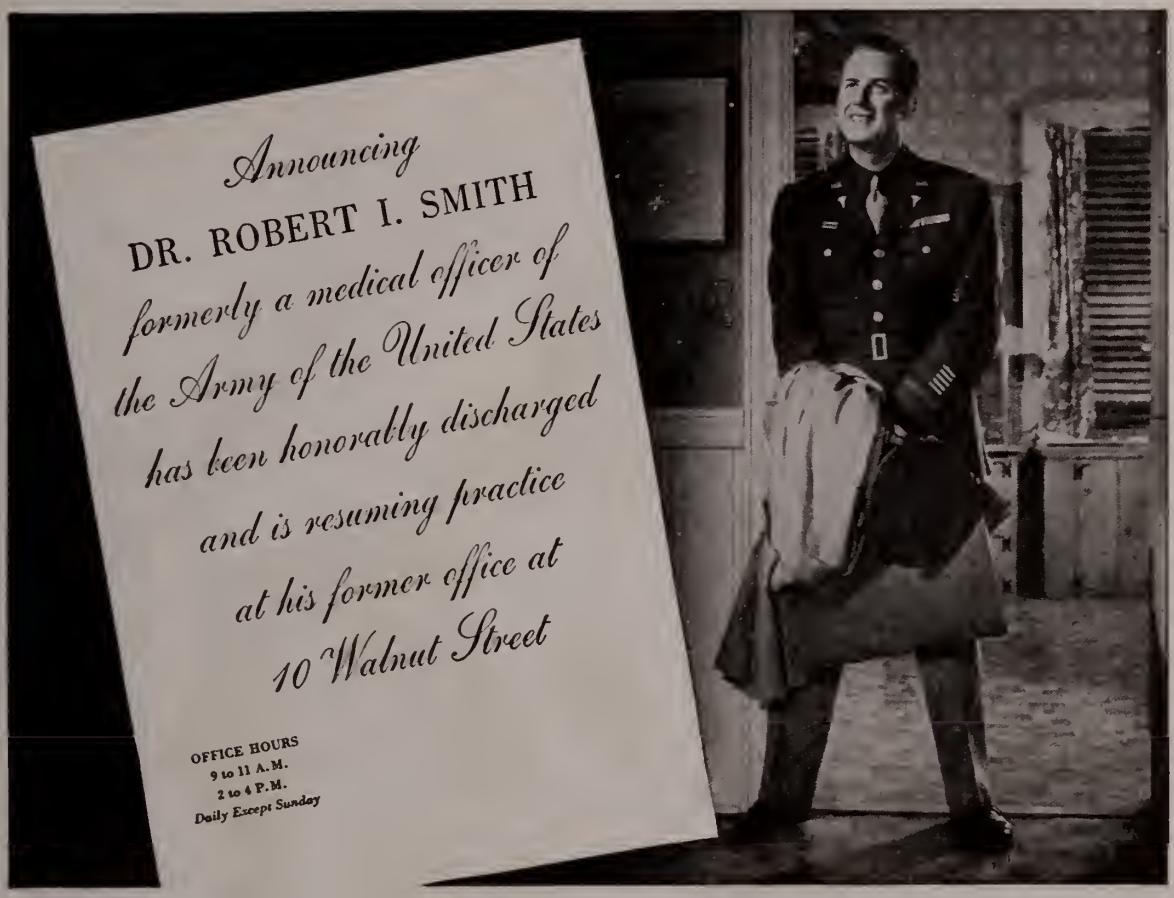
The appealing and palatable taste of Hepatinic assures patient acceptance and particularly recommends the product for pediatrics.

FORMULA: Each fluidounce Elixir Hepatinic contains:

Ferrous Sulfate 12 gr., Crude (Unfractionated) Liver Concentrate (equivalent to 660 gr. fresh liver) 60 gr. Thiamine Hydrochloride 2 mg., Riboflavin 4 mg., Niacinamide 20 mg., together with pyridoxine, pantothenic acid, choline, folic acid, vitamin B_{10}, vitamin B_{11}, biotin, inositol, para-amino-benzoic acid, and other factors of the vitamin B complex.

Bottles of one pint and one gallon. Tasting samples on request.

McNeil Laboratories
INCORPORATED
PHILADELPHIA • PENNSYLVANIA



Welcome Home, Doctor!

Warriors Without Weapons . . . Soldiers in White . . . Marshals of Mercy . . .

The medical men in the war will be the subject of novels, plays, and movies for years to come. But words, pictures . . . statistics, revealing as they are . . . won't begin to tell the whole story of the magnificent work you did. Nor will words be adequate to express fully the appreciation and thanks of your fellow men.

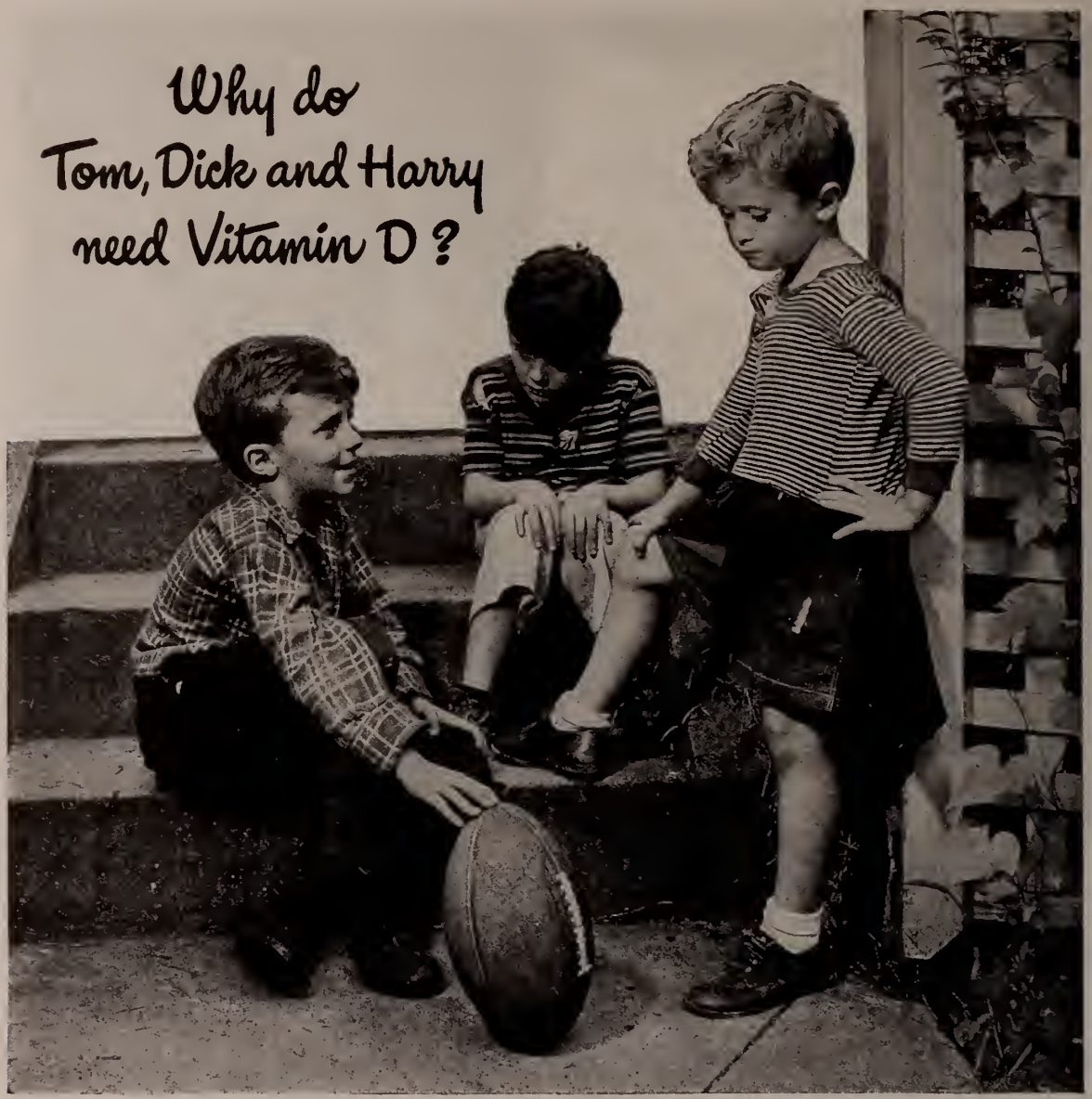
The makers of Camel cigarettes join with millions of others in saying, "Well done, Doctor" and "Welcome home!"



CAMELS *Costlier Tobaccos*

R. J. Reynolds Tobacco Company, Winston-Salem, N. C.

Why do Tom, Dick and Harry need Vitamin D?



Growing children require vitamin D mainly to prevent rickets. They also need vitamin D, though to a lesser degree, to insure optimal development of muscles and other soft tissues containing considerable amounts of phosphorus . . . Milk is the logical menstruum for administering vitamin D to growing children, as well as to infants, pregnant women and lactating mothers. This suggests the use of Drisdol in Propylene Glycol, which diffuses uniformly in milk, fruit juices and other fluids.

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

DRISDOL IN PROPYLENE GLYCOL

TRADEMARK REG U S. PAT. OFF & CANADA

Brand of Crystalline Vitamin D_2 (calciferol) from ergosterol

MILK DIFFUSIBLE VITAMIN D PREPARATION

Odorless Tasteless Economical

Average daily dose for infants 2 drops, for children and adults 4 to 6 drops, in milk.

Available in bottles of 5, 10 and 50 cc. with special dropper delivering 250 U.S.P. units per drop.

WINTHROP CHEMICAL COMPANY, INC.

Pharmaceuticals of merit for the physician • New York 13, N.Y. • Windsor, Ont.

IMPROVED CLEANSING

without HARSH SCRUBBING



in Acne Vulgaris

Better cleansing in acne vulgaris was successfully attained when Acidolate—replacement for soap—was used as the skin cleansing agent in over 400 acne vulgaris patients during a period of four years.[1]

Acidolate, the original and only sulfated-oil detergent with a background of extensive clinical research, offers the following advantages as a skin cleanser in acne vulgaris:—

1. Achieves thorough and better cleansing by gentle massage instead of harsh scrubbing.
2. Removes excess sebum as well as other fatty materials and loosens epithelial debris.
3. Seems to lessen formation of new comedones and facilitates removal of those that do form.
4. The acidity of Acidolate (pH 6.25) approximates that of normal skin and does not change the protective action of sweat.
5. Renders the skin receptive to the action of prescribed therapeutic agents.
6. Insures the patient's cooperation because of early, favorable response to the "Acidolate Massage" cleansing technique.
7. Contains no alkalis, no irritating fatty acids of low molecular weight and no allergenic substances.
8. Water miscible, Acidolate rinses off readily with hot or cold, hard or soft water.

Printed instruction sheets for use of Acidolate by acne vulgaris patients available to physicians on request.

Other indications: *When soap is contraindicated,* as in dermatitis venenata, eczema, seborrhea, etc.; when soap is *inadequate* as in removing residual ointments.

Supplied in
8 oz. and gallon bottles

LITERATURE AND SAMPLE ON REQUEST

Distributed for NATIONAL OIL PRODUCTS CO. *by*

RARE CHEMICALS, INC.
Harrison, New Jersey

1. Swartz, J. H., and Blank, I. H.: J.A.M.A., 125:30 (May 6), 1944.

83J

ACIDOLATE

"Acidolate" Reg. U. S. Pat. Off.

The Preference is Overwhelming

A comprehensive report published in *Human Fertility*[1] shows an overwhelming preference by experienced clinicians for the "Diaphragm and Jelly" method of conception control.

The report covering 36,955 new cases shows that the diaphragm and jelly method was prescribed for 34,314, or 93%.

On the evidence supplied by competent clinicians we continue to suggest that for the optimum in protection the physician should prescribe the combined use of a vaginal diaphragm and spermatocidal jelly.

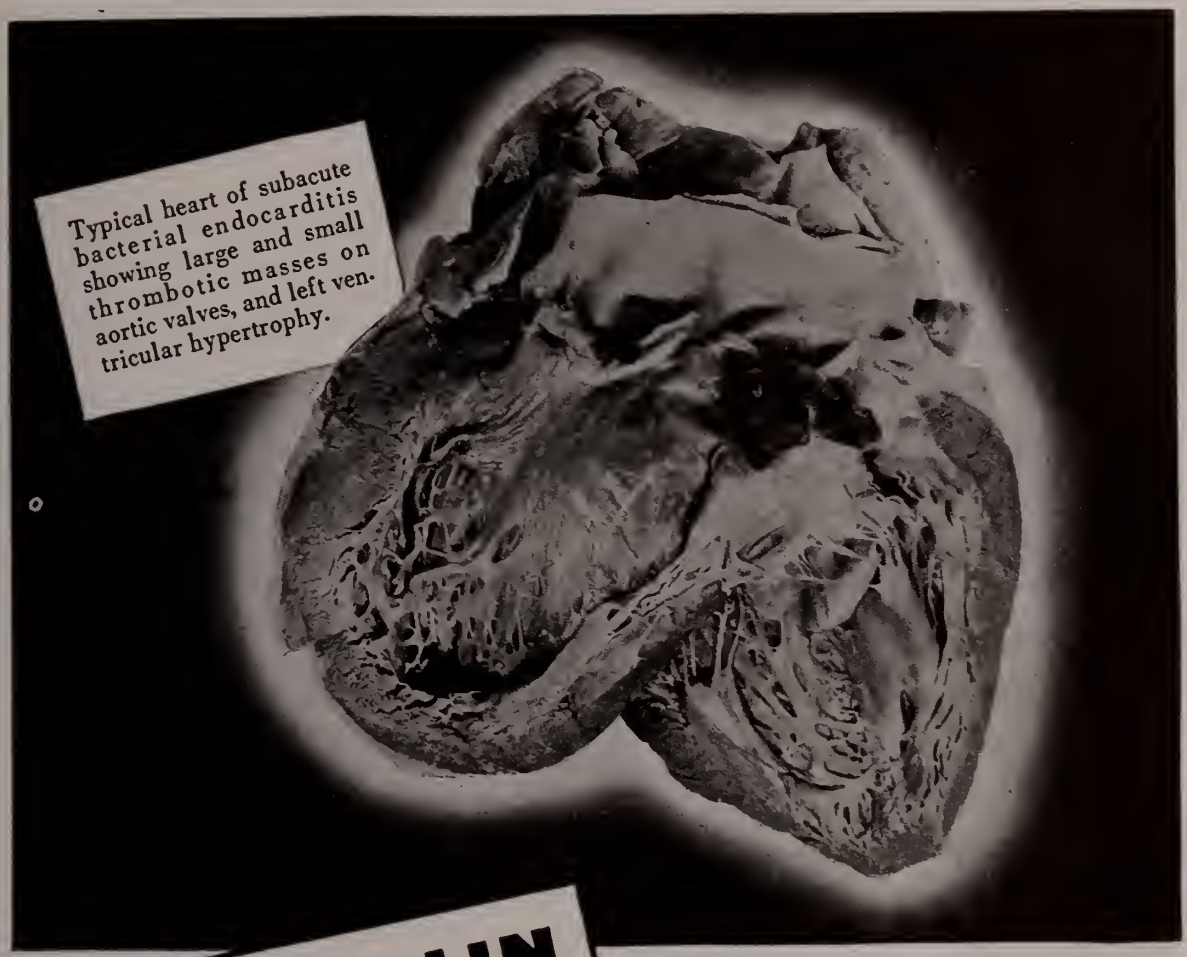
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THEY CALL IT INGENUITY

From the depths of American heritage comes the desire to make something different, to make things better. Call it ingenuity if you will, but the impulse more likely is born of a general unsatisfaction with what we have. Give a boy a new toy, a new gun, a new machine of any kind, and in a few weeks he wants to take it apart to see what makes it go, how it can be improved. That is research in elementary form.

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The Illinois Medical Journal

December, 1945
VOL. 88, NO. 6

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Editorials

THE PRESIDENT'S FIVE-POINT NATIONAL HEALTH PROGRAM

Sometime ago, President Truman informed the public that he proposed to go before the Congress at an early date to give his recommendations for a National Health Program. On November 19, he appeared before Congress and made his recommendations, following preliminary statements and frequent references to the number of young men and young women who were turned down by the Selective Service and recruiting agencies on account of physical defects or inadequate mental capacity. He stated that "as of April 1, 1945, nearly five million male registrants between the ages of 18 and 37 had been examined and classified as unfit for military service."

These statistics have been quoted freely by members of the Congress who have introduced their bills proposing to revolutionize medical care entirely, or in particular fields, as well as those pertaining to the construction of hospitals and health centers, especially in more sparsely settled communities throughout the country. President Truman was proud of the past reductions in our death rates which he stated "come principally from public health and other community services."

First in the five-point program, the President refers to the unequal distribution of physicians and hospitals, stating that more than are needed desire to locate in the metropolitan areas and there is invariably a lack of personnel and equipment in rural areas. In this proposal it is recommended that facilities be made available in these rural areas; then that competent physicians be procured to serve there, and to receive adequate compensation. It is quite obvious that the Hill-Burton Bill and its proposals to establish hospital and health center facilities in rural areas cares for the first recommendation in the President's program.

The second basic need is the development of public health services and maternal and child care, as the President sees it, and he again refers to the more urgent needs along these lines in the rural areas. He proposes services for mothers, infants and children, crippled children, improved sanitary environments and public health services everywhere. In looking over this section of the President's report, one is struck particularly by its similarity to the provisions of the Pepper maternal and child health bill, which was introduced a few weeks ago by Senator Pepper of Florida.

The third part of the five-point program refers to the need for extension of research and education, and to emphasize this need, reference is made especially to the toll taken each year by cancer, and the need for Government aid in promoting research on the cause, prevention and cure of this disease. Then there is need, it is stated, for the establishment of clinics and hospitals for diagnosis and treatment of cancer

especially in its early stages. Mental diseases are likewise discussed in much detail in this portion of the proposed five-point program, with the need for more mental hospitals and research on how to prevent mental breakdown.

In the fourth "Problem", the President referred to the high cost of individual medical care, and gave as the reason for so many people in this country not receiving adequate medical care, their inability to pay for that type of care. He, therefore, proposed a nation-wide compulsory health insurance scheme to cover all people in the country, and those unable to pay the necessary cost by taxation, should be covered by those agencies responsible for their care. Emphasis is made on the statement that this is not "socialized medicine". Once more this part of the proposed program is in accordance with the provisions of the Wagner-Murray-Dingell Bills.

The fifth point in this proposed program is a provision to compensate workers for disability due to sickness, as an extension of social security benefits. In presenting this proposed program, the President urged Congress to begin immediately to take steps to put these recommendations in force.

This proposal, like many which have been previously recommended before The Congress, would place the Federal Government in charge of medical services, medical education, hospitals and everything pertaining to health needs of the Nation, and including, of course, direct supervision over the services of physicians, dentists, nurses, hospitals, and all other groups interested in maintaining the health of the Nation.

Physicians everywhere should study these proposals, as well as other similar legislative proposals which have been introduced in Congress in recent months and be able to confer with their legislators on the subject. It seems quite probable that the annual session of the House of Delegates of the American Medical Association, which is to meet on December 3-6, in Chicago will give a great deal of thought and time for consideration of these proposals, and most likely actions will be taken to formulate definite policies and the establishment of the point of view of the Association. We urge every physician in

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Illinois and elsewhere, to follow as closely as possible these statements of policy which will no doubt be published in much detail in the Journal of the American Medical Association.

THE DOCTORS ARE COMING HOME

During recent weeks the number of medical officers separated from the services has been gradually increasing, and by the end of the year it is believed that the rate of demobilization of medical officers will be greatly increased. It has been announced that after December 15, 1945, the number of accumulated points for separation of medical officers will be decreased from 80 to 70 for the Army, and on January 1 the Navy proposes to reduce their score from 53 to 51 points.

There are some specialists, however, who are to be held for some time as essential regardless of accumulated points. These are especially Ophthalmologists, Otorhinolaryngologists, Plastic Surgeons, Orthopedic Surgeons and Medical Laboratory Officers. The Procurement and Assignment Service for Physicians has been endeavoring to recommend the early release of those older physicians who have been in service for three or more years, and those who are urgently needed for civilian practice in their previous locations. Appraisals of medical personnel in every part of Illinois have been made constantly, and county committees and county medical society officers have been most cooperative in this endeavor.

Hundreds of physicians are looking for suitable locations, and information concerning the medical needs in every county has been submitted to those returning from service who desire aid of this type. In evaluating the medical needs of Illinois, it is quite obvious that very few of the larger cities are actually in need of additional physicians, while there are still a considerable number of small cities where there is a definite opportunity for physicians to quickly build up a good practice. Fortunately in Illinois, with the unexcelled system of hard roads and accessibility of approved hospitals, practice in smaller communities is entirely different from that of a few years ago.

Many of the younger physicians being separated from service are desirous of taking refresher courses, or perhaps resuming their work as residents in approved hospitals with the idea in view of preparing to enter one of the several specialties in medicine. This had been provided in the "G. I. Bill of Rights" and many will no doubt take advantage of this opportunity.

Returning Illinois Physicians will be welcomed in their respective communities, and those desiring to locate for the first time, or to change their locations, will no doubt be given every consideration possible on the part of the older practitioners of the community.

In the November issue of the Illinois Medical Journal we published a list of physicians separated from service from Illinois, and we are adding in this issue of the Journal another list of men who have been reported to the Secretary's office as of November 28. We will greatly appreciate receiving the names and addresses of others who may have been overlooked or whose separation from service was not reported to the Secretary.

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Keller, Robert S., Sandwich
Kenward, Ray L., Paxton
Kobisk, Oliver A., Batavia
Koch, Joseph M., Granite City
Koenigsberg, N. M., Bellflower
Kunde, Emerson C., Woodstock
Lane, Shirley W., Kankakee
Leavitt, Arnold H., Champaign
Leimbacher, Earl S., Joliet
Lepak, Alfred J., Wheaton
LeSage, R. Thomas, Dixon
Lewis, David J., Springfield
Loar, Ralph R., Normal
Lockart, Edmund S., Nokomis
Longwell, Charles W., Nashville
McAllister, Ralph G., DeKalb
McCormick, Loyd J., Moline
McKinley, Hugh A., Highland
McNeely, G. B., Stanford
McNutt, Justin, Bloomington
Martin, Forest R., Decatur
Mathis, John, Peoria
Meltzer, Herman L., Clinton
Moffatt, John S., Rockford
Montgomery, Robert R., Urbana
Murphy, Joseph, Decatur
Mullen, Vincent V., Havana
Neff, Emery B., Moline

Oltman, Diedrich L., East Moline
Ostrom, Meredith, Rock Island
Parker, Forest C., Danville
Partridge, Milton H., Elgin
Pennings, Howard L., Springfield
Perkins, Robert D., Moline
Pettry, Harvey H., Cowden
Potter, Charles C., Alton
Purvey, J. C., Crystal Lake
Prunty, F. C., Urbana
Quandt, Eberhardt, Rockford
Quinn, Everette R., East Alton
Ricketts, F. J., Sadorus
Rumore, Peter C., Effingham
Sala, Roland O., Rock Island
Salzmann, Jay M., Springfield
Sandburg, Carl L., Decatur
Schaller, Edward H., Waterloo
Schilsky, John L., Springfield
Schnicke, Elmer H., Wyanet
Schultz, Alfred G., Jacksonville
Schurmeier, F. A., Elgin
Scott, Walter E., Lexington
Scully, J. C., Algonquin
Seifert, William F., Rockford
Seron, Vaheh M., Joliet
Sheagren, John W., Rockford
Sheehe, Norman L., Rockford
Smith, Carleton R., Peoria
Spencer, Robert A., Beardstown
Stackhouse, Stirling P., Dixon
Steinberg, Richard Mitten, Fairbury
Stephenson, George W., Bloomington
Stilwell, Leland Manford, Champaign
Suttie, Grant, DeKalb
Sutton, Edmund B., Rockford
Svetich, Edward, Joliet
Taubert, Russell K., Pekin
Taylor, J. H., Villa Grove
Teasley, Columbus B. Jr., Robinson
Thompson, Harry G., Mt. Vernon
Thornburg, William, DuQuoin
Tobin, James W., Elgin
Towner, Francis R., Elgin
Turley, Vigo T., Decatur
Utz, Walter J., Peru
Vandermyde, Isaac, Prophetstown
Varney, Harley R., Kewanee
Walker, Wayne R., Pekin
Waller, James B., Decatur
Ward, James A., Metropolis
Warner, Harry R., Kewanee
Wattleworth, Kent L., Newton
Weber, Bernard A., Olney
Weir, Edgar W., Atwood
White, Minor E., Kankakee
Williamson, Holland, Danville
Wilson, Arthur D., Carrollton
Winn, John P., Murphysboro
Wisshack, Erich E., Macomb
Wood, Oliver M., Ipava
Wormley, Gordon W., Rockford
Wrork, Donald H., Rockford
Young, Louis C., Taylorville
Zarcone, Vincent P., Decatur
Zimmerman, Lazar Eli, Elgin

THE REVISED MENTAL HEALTH ACT

The Sixty-Fourth General Assembly passed the Revised Mental Health Act which became effective October 1, 1945. The Act is rather broad and its intent is to facilitate admission of a mentally ill person to a mental hospital. There are three types of admissions:

1. The voluntary application
2. Emergency admission
3. Court Commitment

The *voluntary application* may be signed by the person seeking such admission, if of lawful age, or by his legal representative with the consent of the person. Upon admission to the hospital, the patient and his relatives, parents, guardian, or attorney are informed by the superintendent or his representative of the patient's right to leave the hospital fifteen days after giving the superintendent notice in writing of his desire to leave.

The *emergency admission* is a provision which permits the admission of a patient to a mental hospital upon the presentation to the superintendent one physician's certificate and a petition which is obtained from the Clerk of a County Court. This emergency admission is a period of detention and must not exceed fifteen days, during which period a hearing is held concerning the mental condition of the patient.

The *court commitment* provides that the patient may be admitted as "mentally ill" or "in need of mental treatment." As under the previous mental health acts, a patient admitted as "mentally ill" is deprived of his civil rights. Under the Revised Mental Health Act, if the patient is committed as "in need of mental treatment" the patient loses none of his civil rights.

Appropriate provisions are made for restoration, discharge, and habeas corpus proceedings.

The Act, as it now reads, facilitates admission of patients and still guards the patients' rights and liberties.

BUY VICTORY BONDS

PHOTOS OF MEMBERS FOR PERMANENT RECORDS

Members of the Illinois State Medical Society will soon receive a visit from Mr. Joseph Merante who has taken photographs of the Council, officers and several committees, and who is at present engaged in taking photographs of the individual members of the society.

There will be no charge to the physician for the photograph taken nor will there be any obligation to purchase portraits from Mr. Merante. It is hoped that the membership of this Society will cooperate in this endeavor so that in the near future photographs of the entire membership will be among the permanent records.

WE WOULD RATHER BE FREE THAN SECURE

Though chronologically in our national infancy, we are the richest country in the world. Not only monetarily, but in science, in industry, in commerce, yes, even in art, all other nations look upon us with envy. We have become great not through mere chance or even through our wide natural resources. There are many areas on this globe where coal and oil and minerals are more abundant, and where tillable land is more plentiful than in the United States. We have acquired wealth and admiration because our nation was built on a philosophy of freedom for the individual. And this freedom was not limited to a choice of one's religion or of his liberty to express his views. The individual also maintained his freedom to employ his energies for the purpose of improving his personal status, through competitive enterprise.

It was in this way that our great institutions were created. It was this principle that enabled us to produce the physical and moral weapons which helped liquidate the Axis monsters in Europe and in Asia. We won the war not only because we had the technical machinery to fight WITH, but what is equally important, because we had a sacred heritage to fight FOR. Like our preceding generations we all sacrificed, many bled, and many died, in order that we might retain our human rights as individuals: the right to worship as we please, the liberty to express our opinions, and the freedom to compete with one another in the American way.

In our eagerness to return to peacetime economy many problems are bound to arise. Indeed, some of them are already of a disturbing nature. Labor strikes and lockouts, in some areas, unemployment in others; resistance to price controls by some groups, and the demands for continued regulation by opposing groups, to mention only a few of the problems which now call our attention. These upheavals are not new. Nor, in our estimation, are they dangerous. We have gone through worse crises, and somehow recovered our social equilibrium. Besides, the contest between labor and industry is an essential part of our system of free enterprise. Both institutions have done an admirable job in building America. Left to their own resources they will settle their differences without loss to either side.

What causes us concern are the so-called "liberal" elements in Congress, who attempt to perfect society through legislative fiat. We fear these social reformers more than we do the psychotic rebel rousers. For while the rebel rouser receives encouragement and applause from a comparatively few narrow minded and frustrated individuals, the social reformer draws his support from large masses of honest and decent people who would like to see a better world. The danger, as we see it, lies in the method by which these "liberals" are attempting to cure social ills. Liberty and freedom can neither be attained nor maintained without sacrifices on the part of the individual. The moment that centralized government assumes paternalistic supervision over its citizens, the citizen necessarily becomes a servant of the state. This condition is the keynote to totalitarianism which at first poses as a benevolent agent but in the end enslaves its subjects. It makes little difference whether such initial protective measures favor one class of the population or another; the end result is the same. As the state becomes strong the individual becomes correspondingly weak.

The present efforts to bestow security upon able-bodied Americans are deeper than appears on the surface. The pending EMIC program and the Wagner-Murray-Dingell Bill are only the prologue to the contemplated scheme for "full protection." We contend that the only protectors which can fully benefit our war vet-

(*Continued on page* 283)

State Department of Public Health

THE DEVELOPMENT OF LOCAL HEALTH WORK IN ILLINOIS

RICHARD F. BOYD, M.D., M.P.H.
Chief, Division of Local Health Administration
Illinois Department of Public Health

Local health work in Illinois dates from 1872, the year in which the General Assembly enacted legislation providing for boards of health in municipalities. This action, interestingly enough, preceded by five years the law which provided for the establishment of the Illinois State Board of Health. Under the legislation of 1872, several Illinois cities have developed full-time health departments. The majority, however, have maintained only part-time public health services.

In 1901, the Legislature recognized the fact that there was a need for public health service by rural as well as urban people with the result that legislation was passed providing that the county commission in counties organized under the commission form of government constitute a County Board of Health and that in counties organized under the township plan, there be a Board of Health in each township consisting of the township clerk, supervisor, and assessor.

In 1917, on the basis of a recognition of a need for adequately-staffed local health departments, the Coleman Act was passed permitting the establishment of full-time local health districts consisting of single or multiple adjacent townships or road districts. Subsequently four such local health districts have been organized, namely, the Champaign-Urbana Health District consisting of two townships in Champaign County; the East Side Health District consisting of four townships in St. Clair County; the Quincy Health District consisting of one township in Adams County; and the Berwyn Health District consisting of one township in Cook County. Although this law makes possible the establishment of well-staffed health departments supported by tax funds, the growth of such local district health departments has not been remarkable because of the difficulties inherent in bringing together a sufficient number of adjacent townships to make possible economy of operation. The fact was recognized that in most cases a county is a more logical local jurisdiction in which to establish a local health department, and legislative proposals that would permit counties to establish health departments were introduced at several sessions of the General Assembly. However, for one reason or another, all such efforts prior to 1943 met with failure.

In 1934 the Illinois Department of Public Health which succeeded the Illinois State Board of Health in 1917, began to decentralize its activities by the appointment of 27 part-time district health officers serving as many districts of the State. With the enactment of the Social Security Act by the Federal Congress in 1935, Federal grants-in-aid became available to state health departments for the support of both local and state health work. Since there was no legal authority for counties to establish health departments in Illinois at that time, it was necessary to use these funds for the strengthening of the State district health departments. This was done by the employment of a full-time, specially trained health officer, a public health nurse, a sanitary engineer and a clerk as a minimum staff for each of the district departments. By 1940, 21 State district health departments had

been so established. Each of them included 4 to 7 counties with an average population of 200,000 persons.

This was the situation which existed in 1941, at which time a survey was made of the Illinois Department of Public Health by the American Public Health Association. Out of this survey came a strong recommendation that another attempt be made to obtain legislation permitting counties to establish and maintain health departments and, having obtained such legislation, to promote the development of county health departments, reducing the number of State district health departments as county health departments came into existence.

It so happened that the attack on Pearl Harbor came almost simultaneously with the above recommendation. The need for adequately-staffed local health departments to cope with public health problems arising in overcrowded areas adjacent to military reservations and munitions plants was recognized by the General Assembly when it met in emergency sessions in December, 1941. This recognition took the form of an amendment of the Civil Administrative Code, which gives to the Director of the Illinois Department of Public Health the power to define areas in the State as defense zones for public health purposes and to establish health departments therein and prescribe their duties. As a result, thirteen defense zone county health departments were established, serving fifteen counties as follows: DuPage, Will, Winnebago, Lee, LaSalle, Peoria, McDonough, Fulton, Morgan, Adams, St. Clair, Williamson, Lawrence, Alexander and Pulaski. (The Cook County Public Health Unit was estabilised as a bureau of the Cook County Department of Welfare in 1940.)

In these defense zone county health departments which were established on a war emergency basis, an attempt has been made to maintain a full complement of professional public health workers, including a health officer, staff of public health nurses, sanitary engineer or sanitarian, and a clerical staff. That these health departments have furnished good public health protection is evidenced by the fact that in spite of situations conducive to outbreaks of communicable disease, no wide-spread epidemic has occurred. The services rendered by these full-time health departments on a war emergency basis has also served as a factor in obtaining legislation permitting counties to establish locally autonomous health departments on a permanent basis under the provisions of the Searcy-Clabaugh County Health Law which was enacted by the General Assembly in 1943.

HISTORY OF BIRTH REGISTRATION IN ILLINOIS

The General Assembly of this State in 1877 enacted a Law which became effective in July of that year, creating a Board of Health. The Law provided that this Board should be constituted of seven persons appointed by the Governor.

Among the other provisions of this Law was a regulation requiring the reporting of all births and deaths by physicians and other birth attendants to the County Clerk of the county in which the birth or death occurred.

The Law further provided that the County Clerks of the various counties of the State should be required to render a full and complete report of all births and deaths to the Secretary of the Board of Health annually. The Board of Health was required to prepare such forms for the recording of births and deaths as was deemed proper.

This Law was amended at various times following its passage. Certain amendments were passed in 1901 repealing parts of the Law. One amendment provided for the payment to those making birth reports of a fee of twenty-five cents, which was to be paid by the county.

In 1903 the Act of 1901 was repealed, a provision being made for the reporting of births within thirty days to the County Clerk by physicians, midwives, parents or householders, and further requiring the County Clerk to make a record of all birth and death certificates received by him and file such certificates in his office.

Conditions that arose in 1941 at the time this country became engaged in actual war disclosed the fact that the Law passed in 1877 relative to birth and death records, and the amendments to this Law which were passed at different periods prior to the actual repealing of the Law in 1915, was not effective, as it resulted only in partial birth registration. When the demand was made upon people for certifications of birth records for various purposes such

as Social Security, Old Age benefits and activities connected with the conduct of the war, such as employment in defense plants, thousands of people found that records of their births had not been made at the time they were born. This is shown by the fact that the Division of Vital Statistics of what is now the Department of Public Health was called upon to assist those individuals whose births had not been recorded in the matter of establishing delayed birth records.

In the year of 1941 there were filed 124,652 such delayed birth records. In 1942, in which year the demand had increased greatly, 334,242 delayed records were filed. During 1943, while there had been a drop in filing delayed records, 132,975 such records were established with this Department. In 1944 there were still 43,796 people who were born in the State of Illinois and who found it necessary to establish delayed birth records. The total of such records filed in the four year period was 635,665.

While the Law in existence from 1877 until it was repealed in 1915 provided in a way for the registration of births, there were definite reasons for its not being effective. The requirements insofar as physicians reporting the births were concerned were insufficient, and as no standard birth certificates were issued by the Board of Health to physicians, what reports were made were of a casual nature and the records kept by the County Clerk were in a large number of cases book records and, therefore, inadequate for use in later years as proof of the facts connected with what births were reported.

Further, a large number of births occurring in this period of time were not attended by a physician, and as there were no licensed midwives, those women who served in the capacity of birth attendants, for a friend or neighbor, did not make any report of the event.

In 1915 the 49th General Assembly enacted "The Law to Provide for the Registration of All Births, Stillbirths and Deaths in the State of Illinois." This Act repealed the Law that had been in force since 1877. While the Law became effective July 1, 1915, it really did not become operative until 1916. At that time the State was divided into 2500 registration districts.

In 1917 this Law was amended to require Local Registrars to transmit copies of all birth and death certificates to the County Clerks by the tenth of each month and to also file the original certificates with the State Department of Health at the same time. During this year the Division of Vital Statistics was established and the number of Local Registrars was reduced to 1800. Two special agents to be engaged in field work in connection with registration were employed and machine tabulation of records on file was established. The recording of births and deaths was tested by the U. S. Bureau of the Census and the State was admitted to the registration area for deaths effective January 1, 1918. During this year the medical classification of death causes was changed to conform with the rules of the U. S. Census Bureau.

During 1919 registration districts were further consolidated and the number reduced to 1500. Mechanical sorting and tabulating machines and keypunching machines were added to the equipment of the Division of Vital Statistics and a system of numbering and filing original certificates was adopted.

During 1920 a system of registering "Prior to Act" births by affidavit was inaugurated and the number of registration districts was further reduced to 1400.

In 1922, as the result of a survey made by the U. S. Census Bureau, the State was admitted to the registration area for births.

During 1931 the Law was further amended making a provision which would allow the issuing of new birth certificates upon the basis of adoption decrees, and in 1933 a further amendment was passed to provide for the issuance of a new birth certificate on the basis of the intermarriage of the parents of an illegitimate child. Also, an amendment was passed providing for the issuance of a birth certificate for a foundling child and the further issuance of a new birth certificate in such cases based upon the later identification of the child.

In 1940 the Law was amended to provide for the examination of birth records by health officers for the purpose of ascertaining relative to procedures taken by physicians to prevent ophthalmia neonatorum. A further amendment provided for the issuance of a special certification of birth record limited to a statement of items from the birth record relative to the

name and sex of the child, the names of the parents and the date and place of birth and the date recorded.

During the General Assembly of 1943 the Legislature amended the Law relative to adoptions and also relative to the issuance of new birth certificates on the basis of adoptions, making a provision for the issuance of such certificates in the case of children born in Illinois but adopted in some other State. A change was also made in the Law relative to the establishing of delayed birth records, which change required that the affidavit in such cases should be made by an older relative. A provision was also made for the establishing of delayed records for individuals born in Illinois who did not have any older relative.

The General Assembly in 1945 further amended the Law relative to birth registration in connection with the matter of adoption proceedings and the issuance of new birth certificates on the basis of such proceedings.

By means of the Census taken in 1940 by the U. S. Census Bureau it was possible to make a survey and an estimate relative to the efficiency of the present Law relative to the registration and recording of births occurring in the State. As a result of this survey it was determined that birth certificates were filed as required by the law in over 97% of such cases occurring in the State. Efforts are being made by the Department of Public Health at all times to improve the percentage of birth registration through the activities of Field Agents, who canvass each county of the State for the purpose of checking Local Registrars, Hospitals, Physicians and any other person who may be concerned with birth registration.

WE WOULD RATHER BE FREE
(Continued)

erans and our war workers are JOBS. The way to provide these jobs is through a sound industrial system. Americans like to earn a living and those who believe in insurance like to buy it when they choose and from whomever they choose. Let our "liberals" get down to earth and stop flirting with false philosophies. Security cannot be achieved by compulsion. Even if it were possible it would not be worth the personal dignity and individual self-respect which would have to be sacrificed on the unholy altar of an entrenching bureaucracy. Americans would rather be free than secure.—*Nebr. S. M. Jour., November,* 1945

BLOOD VESSEL RUPTURE IN BRAIN LESS FATAL WITH IMMEDIATE SURGERY

The threat of recurrent hemorrhage and death in approximately 70 per cent of all patients with subarachnoid hemorrhage, a rupture of small blood vessels in the brain, could be removed if it were possible to treat patients effectively and safely by surgery during the first two weeks after the hemorrhage, according to a study reported in the November 10 issue of *The Journal of the American Medical Association.*

George A. Wolf Jr., M.D., Helen Goodell, B.S., and Harold G. Wolff, M.D., New York, wrote that "29 per cent of patients who enter the hospital with subarachnoid hemorrhage die during the first episode of bleeding; 14 per cent die during recurrent bleeding between the second and the fourth week after the intial hemorrhage, and an additional 5 per cent die by the end of the first year."

The authors, who studied 46 patients with subarachnoid hemorrhage at the New York Hospital, said the symptoms included "sudden violent headache, dizziness and vertigo, vomiting, drowsiness, stupor and coma, stiff neck and pain in the back of the thighs and legs, tightness of these areas, sweats and chills."

The investigators concluded from their studies that if patients survived the first year they had a good chance of a relatively long survival, "but the threat of repeated hemorrhage is always present."

Correspondence

CHICAGO MEDICAL SOCIETY'S ANNUAL CLINICAL CONFERENCE

The Chicago Medical Society's Annual Clinical Conference will be held at the Palmer House, Chicago, March 5, 6, 7 and 8, 1946. The program committee has invited outstanding members of the medical profession to present papers of general interest to all the profession. The space in the Exhibition Hall has been completely allotted to a carefully selected group of Technical Exhibitors and the Committee on Scientific Exhibits is busy processing the large number of applications submitted for presentation at this meeting. These plans assure the success of this the first major general meeting in Chicago since the cessation of hostilities. It should prove intensely interesting to all physicians in and near Illinois.

ANNOUNCEMENT OF VAN METER PRIZE AWARD

The American Association for the Study of Goiter again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association which will be held in Chicago, Illinois, in April or May 1946, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a typewritten double spaced copy sent to the corresponding Secretary, Dr. T. C. Davison, 207 Doctors Building, Atlanta 3, Georgia, not later than February 20th, 1946. The Committee, who will review the manuscripts, is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for presentation of the Prize Award Essay by the author if it is possible for him to attend. The essay will be published in the annual Proceedings of the Association. This will not prevent its further publication, however, in any Journal selected by the author.

CORRECTION PLEASE!

Dear Doctor Camp:

I wonder if I might take the liberty of calling to your attention an error which occurred in the article, "Penicillin Reaction in the Treatment of Gonorrhea" which appeared on page 178 of the October, 1945, issue of the Illinois Medical Journal.

The second sentence in the first paragraph of this article is very confusing as printed and in all probability is a result of an oversight on the part of the printers. The sentence should read as follows: "The amount of drug used in treating the latter disease, 100,000 to 200,000 units, is totally inadequate for the 'cure' of syphilis which, it is believed now, requires a minimum of at least 1,200,000 units."

I mention this correction with the thought that perhaps you might like to make note of it in the next issue of the Journal.

Yours very truly,
Leslie W. Knott, M.D.
Medical Administrative Assistant
Department of Public Health,
Springfield

NOTICE

I should like to hear from all Physician Anesthetists in Illinois who are interested in forming a state organization. A group of this kind, which might be called The Illinois Society Of Anesthesiology, would be much more effective in representing the interests of Anesthesiologists in the state than the Chicago group, which represents only a small geographical area. Please write me your views on the subject so that we can begin to take action early in 1946.

James H. Bennett, M.D.
2650 Ridge Ave., Evanston, Ill.

MISSISSIPPI VALLEY MEDICAL SOCIETY 1946 ESSAY CONTEST

The Mississippi Valley Medical Society is resuming its annual Essay Contest which has not been held during the war. In 1946 it offers a cash prize of $100.00, a gold medal, and a certificate of award for the best unpublished essay on any subject of general medical interest (including medical economics) and practical value to the general practitioner of medicine. Certificates of merit may also be granted to the physicians whose essays are rated second and third best. Contestants must be members of the American Medical Association who are residents of the United States. The winner will be invited to present his contribution before the next annual meeting of the Mississippi Valley Medical Society to be held at St. Louis, Mo., September 25, 26, 27, 1946, the Society reserving the exclusive right to first publish the essay in its official publication — the MISSISSIPPI VALLEY MEDICAL JOURNAL (incorporating the RADIOLOGIC REVIEW). All contributions shall not exceed 5000 words, be typewritten in English in manuscript form, submitted in five copies and must be received not later than May 1, 1946.

Further details may be secured from
Harold Swanberg, M.D., Secretary,
Mississippi Valley Medical Society,
209-224 W. C. U. Building, Quincy, Illinois.

PHYSICIANS NEEDED AT HINES

It has come to the attention of the Secretary's Office that there is an urgent immediate need for 18 physicians to fill positions on the rating boards at the Veterans Administration Center at Hines, Illinois.

This need is necessitated by the many claims being filed by servicemen who are being discharged from the armed forces. The position of Rating Specialist, Medical, is presently classified in the Professional and Scientific Group under Grade P&S-4. The basic entrance salary is $4300 per annum and with the overtime schedule of eight hours presently in operation, the aggregate annual rate is $5092.

The duties of a Rating Specialist, Medical, relate to determinations made by rating boards regarding the question of service connection of injury or disease, either by direct incurrence in active service with the armed forces, or aggravation of a disease or injury which is shown to have pre-existed such service; and further, to determine the degree of disability resulting from such disease or injury held to have been so incurred or aggravated during active service.

Rating Specialists, Medical, have daily work hours from 8:00 A.M. to 4:30 P.M., 6 days weekly, including eight hours of overtime.

Arrangement for interview concerning the further particulars relative to the position of Rating Specialist, Medical may be made with Mr. A. B. Chadwick, Adjudication Officer, at Hines, Illinois, either by letter or telephone. The telephone number is Columbus 6700, Extension 267.

NEW SCHERING REPRESENTATIVE IN CHICAGO

Schering Corporation, with plants in Bloomfield and Union, New Jersey, manufacturers of important endocrine and pharmaceutical products for the medical profession, has appointed Chester A. Jarecki, Professional Service Representative in Chicago. Mr. Jarecki is a graduate of the University of Illinois College of Pharmacy and has had experience in retail pharmaceutical practice.

Great progress has been made in control of tuberculosis; equally obviously, much remains to be done. It may be said with fairness that no locality or state of the Federal Government has ever conducted an even reasonably adequate program for the control of the disease. Narry S. Mustard, M.D., Government in Public Health, The Commonwealth Fund, 1945.

There is no more important function of government than the protection of the public health. Mayor Theodore R. McKeldin, Balt., Md.

Medicine's Role in the War Effort

RECONVERSION OF THE 9-9-9 PROGRAM

The 9-9-9 program was devised in order to supply American hospitals with residents. Without it every commissioned officer, which represented 80 per cent of each class, would have been called to active duty at the end of twelve months of internship and the American hospitals would have been practically devoid of residents. The Procurement and Assignment Service made arrangements with the Surgeons General so that a sufficient number of officers could have their active duty orders delayed and the hospitals could have a minimum supply of residents with which to operate during the war. The whole plan constituted a loan of military personnel to civilian institutions by the Surgeons General, and they were willing to enter into the plan because it was perfectly obvious that there was no other supply available with which to keep these hospitals operating.

Increasing numbers of veterans who have seen active duty are becoming available for filling such positions, and therefore the Surgeons General are convinced that it is in order to call to active duty as rapidly as possible every commissioned officer who has not been on active duty. Hospitals, therefore, must begin at once to appoint veterans to every staff position so that, with rare exception, every military resident can be called to active duty not later than April 1, 1946. As soon as a veteran has been adequately trained to replace a commissioned officer resident, that officer should be called to active duty at once without regard to whether or not he has completed the full term of his present deferment. The hospital must notify the state chairman for physicians of the Procurement and Assignment Service of the availability of such officers at once. State chairmen must watch these developments closely. At present veterans will not count in hospital quotas and it will be of great advantage to the hospitals to accept veterans as replacements for the officers who do count in quotas. The great advantage to hospitals in accepting veterans promptly is that they will be orientated to their position before April 1 in anticipation of the fact that after July 1 such veterans will be practically the sole source of supply of residents for civilian hospitals.

Hospitals and commissioned officers now serving as residents are reminded that any contract with hospitals is wholly subsidiary to their legal obligation to the Army and Navy and that each individual is subject to active duty orders at the discretion of the Surgeons General.

Present deferments were granted by the Surgeons General prior to VE day when there was no other supply available to the hospitals. In many institutions veterans are applying by the scores for hospital appointments, and hospitals should accept them to the greatest extent possible in anticipation of the fact that those not having been on active duty will be called.

In those cases in which the hospital desires the services of an officer on active duty in the Army to fill a residency and the hospital is willing to release a deferred commissioned resident who has not been on active duty before the termination of his present deferment period in exchange and he is an officer (1) who has been on active duty for two years or more, (2) who is now stationed within the continental United States and (3) who would accept the appointment, a request for the release of that officer under War Department Circular 296 through the Procurement and Assignment Service will receive immediately prompt and favorable consideration by the Surgeon General of the Army. This replacement possibility does not extend to officers on duty with the Navy.

The Procurement and Assignment Service will continue to recognize its responsibility toward the hospitals, and in those individual instances, very limited in number, in which hospitals are unable to secure a veteran after exhausting every effort or an officer who qualified under the War Department Circular 296 will be given consideration by the Procurement and Assignment Service and the Offices of the Surgeons General. Subject to the foregoing general provisions the reconversion from the 9-9-9 program to a peacetime twelve month service will be conducted in accordance with the following plan: (This outline applies to the April group. Information concerning those who finish their present term before April and after April will be released in the near future.)

SECTION I

A. Each commissioned officer who is an intern terminating his nine months of internship on April 1, 1946 will continue in his present internship until July 1, 1946. (For exceptions see section II.)

B. Each commissioned officer who is a junior resident terminating his junior residency on April 1 (if he has not already been replaced by a veteran prior to April 1) will be called to active duty on April 1 except in rare cases in which special request for his service is submitted to and approved by the Procurement and Assignment Service and the Surgeon General, such request to be effective only until he is replaced by a veteran and not beyond July 1, 1946.

C. Each commissioned officer who is senior resident and who is completing his twenty-seven months of service in a hospital following graduation will be called to active duty on or about April 1, 1946 if not replaced prior to that date by a veteran.

D. Senior students who graduate on or about April 1, 1946 are to be accepted for internship on that date. This new group of interns will be allowed to serve internships until July 1, 1947. This means that hospitals would have a maximum of twice their quota of interns from April to July and their quota of interns from July to the following July. In view of this and in order to maintain equitable distribution of the intern supply, quotas for interns will be maintained at their present levels.

SECTION II

A. The present interns (referred to in paragraph A, section I) will be called to active duty on July 1, 1946 except (1) those who are called to duty between April 1 and July 1 because the hospitals cannot facilitate both the old and new groups of interns for three full months of overlapping service; and (2) those rare cases in which their services are absolutely essential for an additional period in civilian hospitals. Their services will be deemed necessary only in those cases in which the Procurement and Assignment Service and the Surgeons General are convinced that every effort to obtain the services of veterans, physically disqualified or otherwise ineligible men or of women has been made. [N. B.: If Congress votes funds to continue the ASTP beyond June 30, 1946 the military group in the following class (unless the Army Training Service abandons its present accelleration demands) will become available for internship on Jan. 1, 1947. This would produce a six month overlap from January to July, but it is hoped that this can be avoided.]

B. The present junior residents (referred to in paragraph D, section I) will be called to active duty as soon as replaced by a veteran with the same exceptions stated in paragraph A, section I.

C. (Blank).

D. The new graduates (referred to in paragraph D, section I), who will complete twelve months of internship on or before July 1, 1947 will be called to active duty on that date. These men may have as much as fifteen months of internship, that is, April 1, 1946 to July 1, 1947.

SECTION III

By April 1, 1946 hospitals will be almost entirely dependent on nonmilitary personnel to fill residencies.

This program does not contemplate an interference with the present policy of not including veterans in quotas. In fact, it emphasizes the importance of acquiring the services of such veterans at the earliest possible moment so that they will be adequately trained to serve as replacements for officers now deferred to April 1 and for the period when they will represent practically the entire supply—after July 1, 1946.

In the interest of adequate distribution of the available supply of veterans, it is expected that hospitals will not fill their house staff out of proportion to present quotas. These veterans should be used first as replacements, and present quotas for residents should not be exceeded until all deferred commissioned officers who have not been on active duty have been released from that particular hospital. This is not contrary to the policy of not counting veterans in quotas until they are sufficiently trained to be used as replacements.

It will not be necessary to submit forms 218 for the continuation of interns for the period from April 1 to July 1, referred to in paragraphs A and B, section I. It will be presumed, however, that the junior residents referred to in paragraph B, section I, practically without exception, will not be requested for this period and will be released prior to but not later than April 1 and as soon as they can be satisfactorily replaced by officers discharged or separated from the service.

The necessity of reconverting from the 9-9-9 program as rapidly as possible cannot be emphasized too strongly and to the greatest extent possible for the purpose of returning to the July to July twelve month internship this coming year. The most available and safest supply of physicians to serve residencies will be these who have completed their military obligation to the nation during the war and the duration of the emergency.

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PROGRAM FOR DEFERRED RESIDENTS OF MEDICAL CORPS

Following is the modification of the program for deferred residents of the Medical Corps, published recently in War Department Circular No. 296, which will be effective until March 28, 1947 unless sooner rescinded or superseded:

1. General and Eligibility. a. Medical Corps officers on active duty as explained below are eligible for release from active duty to accept residencies or fellowships in civilian hospitals. Upon their release, they must be replaced by a Medical Corps officer now on inactive duty and serving as a resident or fellow in the hospital to which the officer being released will report for postgraduate training.

b. Criteria for eligibility:

(1) Must have been on active duty prior to Jan. 1, 1943.

(2) Must be under 40 years of age.

(3) Must not be eligible for release from active duty under other War Department directives or army regulations.

2. Applications. Procedure for filing:

a. Application for determination of eligibility for release should be addressed to the Adjutant General (attention

Officers' Branch, Separation Section, Munitions Building, Washington, D. C.) through military channels. Application should be accompanied by a true copy of WD AGO form 178-2 or 66-3 in duplicate with a 2 by 2 inch passport type photograph attached.

b. A statement must accompany the application indicating that the criteria mentioned in paragraph 1 b apply. In addition the following information must be furnished:

(1) Name of hospital in which residency or fellowship is desired. In this connection, first consideration should be given to applying for a residency or fellowship in the hospital in which the officer received his original training if the hospital has Medical Corps officers on an inactive status serving as residents or fellows.

(2) A second and third choice of hospital will be given.

(3) In the event applicant has already received an appointment from a hospital this fact will be clearly stated, giving the date the appointment was received, the type of residency or fellowship and the period of time during which the appointment will be effective.

(4) No hospital should be named which does not have Medical Corps officers on an inactive status serving as residents or fellows.

3. Forwarding of Applications. a. All applicants will be forwarded through military channels to the Adjutant General (attention Officers' Branch, Separation Section, Munitions Building, Washington, D. C.) for forwarding to the Surgeon General regardless of whether the application is approved or disapproved by forwarding commander.

b. The first forwarding indorsement will include the following statements:

(1) Approval or disapproval.

(2) There is (or is not) an overall surplus in the command jurisdiction of officers qualified and available to fill the duty assignments for which the officer concerned is qualified.

(3) A replacement will (or will not) be required and is (or is not) readily available.

(4) Services of the officer have been such as to entitle him to separation under honorable conditions.

(5) No disciplinary action or reclassification proceedings under AR 605-230 are pending or appropriate in the case.

(6) No hospital disposition board or Army retiring board proceedings are pending or believed to be appropriate.

c. Subsequent forwarding indorsements will include statements of approval or disapproval and such other remarks as may be deemed pertinent.

4. Action of the Surgeon General's Office and Procurement and Assignment Service, War Manpower Commission. a. Upon receipt and approval of the application by the Surgeon General, the application will be noted and forwarded to the Procurement and Assignment Service, War Manpower Commission, which service will act as intermediary agent between the War Department and the civilian hospital. The approval or disapproval of the application by the civilian hospital will be returned to the Surgeon General through the Procurement and Assignment Service, War Manpower Commission, accompanied by the name of a Medical Corps officer on inactive duty, who will be released by the hospital for active military service.

b. Upon receipt of an approved application from the Procurement and Assignment Service, War Manpower Commission, the Surgeon General will forward the papers to the Adjutant General (attention Officers' Branch, Separation Section, Munitions Building, Washington, D. C.) giving the date the separation is to become effective and concurrently advise the applicant through military channels of the approval of the application and the date the applicant will be released from duty.

c. Concurrently with action taken in b above, the Surgeon General will request that orders be issued assigning the Medical Corps officer who is serving as a resident or fellow on an inactive status to active duty. The effective date of active duty will be ten days later than the date at which medical officer released from active service will report to the hospital.

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MAGNUSON BECOMES ASSISTANT TO HAWLEY

Dr. Paul B. Magnuson, Chicago, has accepted a post in Washington as assistant to Major Gen. Paul R. Hawley, Surgeon General of the Veterans Administration. His duties will be connected with a plan to appoint civilian doctors to veterans' hospitals, especially civilian doctors who have seen service in the Army in the second world war, and whose record indicates that they have been devoted to their duties and service to the soldier.

Dr. Magnuson has taken a leave of absence from his duties at Northwestern University Medical School as professor of bone and joint surgery and will devote his full time during the next few months to this assignment. He is not permanently giving up practice or teaching in the medical school and plans to return to his practice as soon as the organization of veterans' care is well under way. This, as indicated now, should not be more than six months.

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LIEUTENANT COLONEL ALFRED CAMPBELL LEDOUX

Lieut. Col. Alfred Campbell Ledoux, formerly of Evanston, Ill., was recently awarded the Bronze Star. The citation read, in part, "Lieut. Col. Alfred Campbell Ledoux, while serving in the Army of the United States, distinguished himself by meritorious service in connection with military operations not involving aerial fight against an enemy of the United States. As chief of the x-ray service, 108th General Hospital, Lieutenant Colonel Ledoux was instrumental in the discovery, the reconstitution of and the early adaption of captured German x-ray and radiotherapy equipment. This was accomplished by virtue of his initiative, specialized technical knowledge and highly professional attainments. The immediate availability of this splendid equipment at a time when transport of our own equipment was extremely difficult and uncertain, owing to the exigencies of the military situation, materially assisted in the diagnostic care and treatment of many thousands of casualties." Dr. Ledoux graduated from Tufts College Medical School, Boston, in 1929 and entered the service Jan. 1, 1943.



Original Articles

COMPOUND FRACTURES

A First Priority Emergency.
A Plea for an Adequate Plan for Definitive Treatment.

EDWARD L. COMPERE, M.D.
CHICAGO

The only difference between a compound and a simple fracture lies in the fact that in the former injury there is a break in the skin with direct communication from the outside to the site of the fracture. A compound fracture constitutes a real emergency. Unless the wound itself is cared for promptly and adequately, infection may be expected. Infection of the wound of a compound fracture may lead to osteomyelitis, septicemia, nonunion, prolonged invalidism, loss of limb, or death.

A compound fracture may be treated in one of four different ways. Two of these procedures are definitely bad and may be expected to produce poor end results. Either of the other two, if used in properly selected cases, may be expected to bring about recovery with a minimum loss of time and with very little permanent disability. The first two of the four procedures referred to are:

1. — The wound of the compound fracture is left alone. Some type of antiseptic (most commonly iodine) is poured into the wound, a dry dressing is applied and the surgeon sits down to wait to see what will happen. There is no adequate cleansing, no debriding and any foreign material which was in the wound when the patient was brought to the doctor remains there. Infection in these instances is more often the rule than the exception. (Figure 1 and Figure 2)

2. — The wound is treated with a strong antiseptic, is either cleansed inadequately or not at all, and either inadequately debrided or this pro-



FIGURE 1: Deformity and persistent infection 7 years after compound fracture of both bones of both lower legs of a patient who was inadequately treated.

From the Department of Bone and Joint Surgery, Northwestern University Medical School.



FIGURE 2: Roentgenograms of left and right lower legs showed unhealed compound fractures. Total permanent disability resulted from failure to successfully prevent infection by rendering the best possible difinitive care.

cedure is entirely neglected. In spite of the fact that there has not been the necessary cleansing of the extremity or of the wound, with removal of all foreign material and all devitalized tissue, this wound may be closed. This is not a common error, but when a surgeon makes this mistake the most serious consequences are to be anticipated. Not only infection but gas gangrene may follow such poor medical practice in a rather high percentage of the cases.

One of the first patients that I had the opportunity of treating, in which the compound fracture had been managed in the manner described above, was the fourteen-year-old daughter of a prominent Detroit banker. The car in which she was riding had overturned and the elbow of this young patient had been dragged beneath the side of the car and against a sand and gravel bank. She was given initial care by a physician in one of the smaller towns in central Michigan. I saw her approximately 30 hours after the accident when she was admitted to the Henry Ford Hospital in Detroit where I was a member of the house staff. The arm was extensively swollen. There was crepitus and cyanosis from the shoulder to the finger tips. The wound in the region of the elbow had been closed tightly. When the stitches were removed and the wound was opened, foul smelling pus with quantities of gas escaped. Multiple incisions were made for drainage and the jagged lacerations were washed with several liters of sterile water and soap. Approximately one-half teacup of gravel and sand was removed. Some of the bits of gravel were one centimeter in diameter. This foreign material had been sewed into the wound. The arm was saved, but inefficient cleansing and neglect of debriding on the part of the doctor who had rendered the initial care, almost cost the life of this patient.

It should be emphasized at this point that the general practitioner, and especially the man who is trained in the discipline of general surgery, has the greatest opportunity of rendering service to patients who have suffered from compound fractures. The specialist only occasionally sees these patients soon enough after the injury oc-

curs to render the care that is urgently needed if infection is to be averted.

We have discussed two of the ways in which patients may be incorrectly treated for their compound fractures. The intelligent and well-trained surgeon may not be qualified to give the best care in the reduction of the fracture and in promoting healing of the broken bone without deformity or loss of function, but he should at least be able to deal with the wound. The care of the fracture itself is of secondary importance. *At the earliest possible moment the wound of the compound fracture should be thoroughly cleansed, the skin about the wound scrubbed and the wound itself adequately debrided.* After this part of the treatment has been carried out the wound may:

3. — be left open, or

4. — be primarily closed, using interrupted silk stitches for the skin. If no buried catgut is left in the wound and no drains are inserted, this procedure may change the compound into a simple fracture.

It would seem obvious to anyone who has had training in surgical methods that the ideal in the management of compound fractures would be to try to obtain primary healing of the wound and thus change the compound fracture into a simple fracture.

Laudable pus was considered by the best surgeons of a few generations past as a necessary or even ideal method of healing a wound. Healing by primary intention was the exception rather than the rule. Too often the physician added insult to injury by filling a relatively clean wound with boiling oil, hot pitch, or a corrosive chemical.

The physician does not heal wounds or knit fractures. Forces of repair inherent in the body of each living organism, working in accordance with the laws of nature, perform the healing process. The physician should be qualified by training to play a very helpful role in this drama. It is his responsibility to assist the repair by removing obstacles or correcting, insofar as possible, influences which may inhibit the healing of the wound or the knitting of the fracture.

The following outline presents the treatment program which is recommended for the fresh compound fracture.

Emergency Care At Site Of Accident — 1. Give morphine sulfate, ¼ grain, for pain *unless there is a head injury.* Omit morphine if the patient is a small child. 2. Treat shock — control bleeding and apply external heat; give warm fluids by mouth if the patient is conscious.

3. Clamp the severed blood vessels that are spurting blood.

4. Sprinkle the wound with sulfanilamide and cover with sterile pressure dressing.

5. Apply an adequate splint *before moving the patient.* This will lessen shock and prevent further damage to soft tissues.

6. Transport the patient to a hospital without unnecessary delay — on a stretcher if the spine, pelvis, femur, or tibia is involved, or if the patient is unconscious.

7. Apply tourniquets only when absolutely necessary to stop hemorrhaging. They are dangerous. They may be forgotten, with resulting gangrene.

Hospital Care — 1. Continue treatment of shock while the operating room is being prepared. Apply warm blankets and hot water bottles. Administer adequate amounts of plasma, whole blood or glucose and saline.

In deep shock, give continuous blood plasma or whole blood, or both. Do not stop after one transfusion if shock is not relieved.

Search for other injuries — to the brain, a ruptured viscus or hemorrhage into adrenals.

2. As soon as the patient's condition permits, excise the wound *in the operating room.* (Figure 3)

a. Place the leg on a fracture table in the traction stirrups.

b. Continue the administration of fluids intravenously if they are needed.

c. Obtain roentgenograms while the operator scrubs his hands for ten minutes and dons sterile gown and gloves. The nose and mouth must be covered.

d. Apply skeletal traction, if indicated.

e. Scrub the skin for ten minutes with white soap and sterile cotton while protecting he open wound with a sterile towel. (If scrubbing is not feasible, use benzine or ether and iodine on skin, but *not in wound.*)

f. The operator should change his gloves. Drape the wound area with sterile towels. Wash the interior of the wound for ten minutes, using white soap and water. Irri-

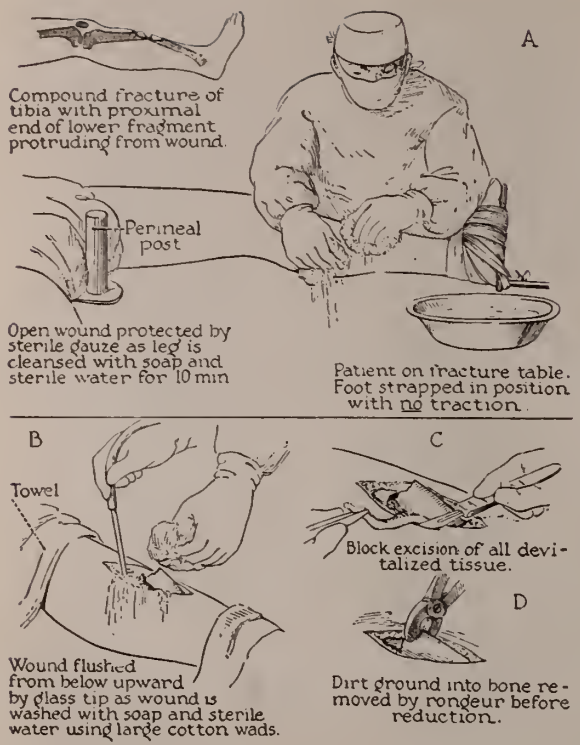


Figure 3: Cleansing and debridement of compound fracture wound. (*From Compere and Banks, Pictorial Handbook of Fracture Treatment, page 53; The Year Book Publishers, Chicago, Illinois.*)

gate from below upward with large volumes of warm sterile physiologic salt solution. Again change gloves.

g. Excise the walls of the wound. Start from the skin and go downward (debridement). Obtain hemostasis.

h. Rongeur away all infected bone.

i. Remove only the completely detached small fragments, *no* large fragments.

j. Reduce the fracture. Immobilize with a metal plate if the position of fragments is unstable.

k. Repair severed tendons and nerves if it seems that infection is unlikely to occur.

l. Frost all recesses and surfaces of the wound with sulfanilamide crystals.

3. Decide whether the wound shall be sutured or packed open.

a. *Close the wound* without tension if the patient is treated within six to eight hours after injury.

(1) Bury little plain catgut. Do not bury chromic sutures.

(2) Do not suture muscles or fascia.

(3) Make parallel skin incisions to effect closure if necessary.

(4) Apply split-skin grafts to secondary wounds.

b. *Leave the wound open.* Insert sulfanilamide-vaseline-impregnated gauze if the patient is seen after eight hours or if it is the surgeon's opinion that the wound should not be closed, even though less than eight hours have elapsed before excision. The open pack method should be compulsory if (1) there are multiple wounds, (2) The surgeon is not experienced in compound fracture surgery, or (3) the patient must be evacuated from a combat area.

4. Immobilize the fracture adequately with plaster dressing. Permit the patient to be ambulatory on crutches, if at all possible. The Roger Anderson multiple pin method, in conjunction with plaster or external metal bar, leaving all joints free, may be used by those experienced in the technic. The internal splinting of unstable compound fractures by nonirritating metal plates and screws, in conjunction with plaster casts, may be used by those who have had training and experience with this method. (Figure 4)

5. Give tetanus antitoxin, 3,000 international units.

6. Give gas bacillus antitoxin if the wound is contaminated with dirt from the highway or cultivated fields.

7. Administer sulfathiazole or sulfadiazine routinely in full doses by mouth.

8. Give 20,000 units of penicillin intramuscularly every three hours.

Too much emphasis cannot be placed on the importance of performing an adequate débridement. This does not mean the mere cutting away of skin margins, as so many students are led to believe from inadequate descriptions of this procedure in their textbooks. It means the excision en masse of all devitalized and contaminated tissues except major nerves and blood vessels. The use in the wound of iodine, benzine or other strong antiseptics which devitalize living cells and predispose them to infection is definitely condemned. The use of the sulfonamides can-

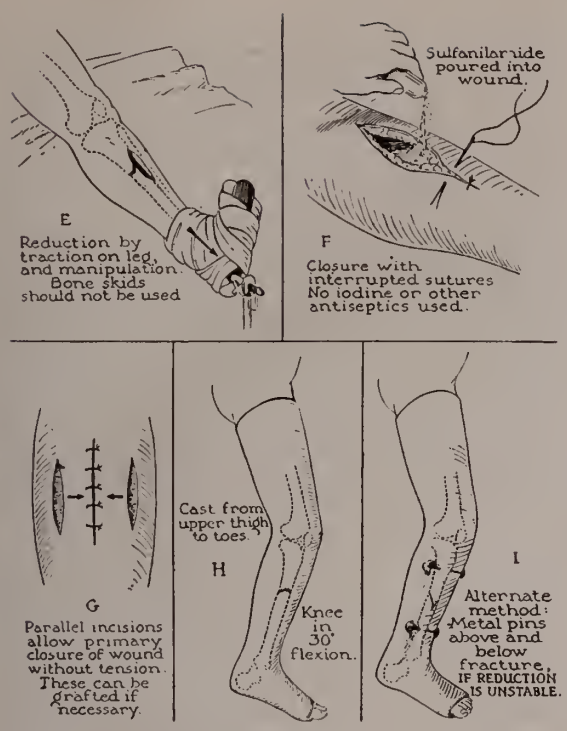


Figure 4: Immediate reduction, primary closure of wound and immobilization of the fracture. (*From Compere and Banks, Pictorial Handbook of Fracture Treatment, Page* 55: *The Year Book Publishers, Chicago, Illinois.*)

not compensate for inadequate excision of the wound. It has been shown by comparable series of cases that unless adequate débridement is performed, the incidence of infection in compound wounds treated within eight hours is not lowered materially by the local use of the sulfonamides.

For the physician who has had little actual experience and training in fracture management and cannot perform a skillful cleansing and débridement of the wound or is not able to provide adequate aftercare of the patient, the open method is undoubtedly safer under all circumstances.

There are certain theoretical advantages of primary suture of compound fractures:

1. This method, when successful, turns compound into simple fractures.

2. Both primary and secondary infection is avoided, and osteomyelitis is prevented.

3. Healing of soft tissues is complete in ten to twelve days.

4. The scar is linear and nonadherent.

5. The hospitalization period is decreased.

6. The period of disability is lessened.

Contraindications to primary closure of compound fracture wounds may be summarized as follows:

1. Wounds over eight to ten hours old.

2. Wounds widely contused.

3. Prevalence of gas organisms in the geographic area, with definite contamination of the wound.

4. Inadequate débridement owing to presence of major vessels and nerves.

5. Tissues under tension. (These may be relaxed by incision of the skin at a distance from the wound.)

6. All war wounds, which are often multiple, including compound fractures.

Patients with compound fractures who arrive at the hospital for care after suppuration is definitely established, or too long after injury to permit of primary closure, should be treated by the Orr method.

The well trained surgeon in civilian practice can and should cleanse, débride and close all wounds of compound fractures seen within eight hours of injury. War wounds may have to be treated by physicians who have not had wide training in surgical technic and the principles of thorough cleansing and débridement of contaminated wounds or the discipline needed in the management of major fractures. Under these circumstances, the wounds should be washed, cleansed with warm saline, débrided as well as possible, packed loosely with sulfanilamide-vaseline-impregnated gauze and immobilized; and the patient should then be transported as soon as possible to a medical center for further treatment of the fracture. Sulfathiazole or sulfadiazine, 4 Gm. by mouth, should be given as soon as possible after the injury, and 1 Gm. four times daily. Penicillin, 20,000 units intramuscularly, should be administered every three hours until temperature remains normal for four consecutive days.

Natural or racial immunity to tuberculosis has long been a controversial question. However, it is generally accepted at present that resistance to the disease by Indians is less than that shown by whites when judged by the standards of morbidity and mortality rates and the X-ray appearance of lesions. J. R. McGibony, M.D., & A. W. Dahlstrom, M.D., Am. Rev. Tbc., Aug., 1945.

MEDICAL CARE FOR VETERANS

PAUL R. HAWLEY, Major General
Medical Director, Veterans' Administration

I am going to present to you very briefly and very frankly what we have in mind to improve the medical service of the Veterans' Administration.

It falls into two large problems, one of institutional care of the sick and injured veteran and the other is out-patient care. I presume the large bulk of the membership of the component societies here is interested more in out-patient care than in institutional care and I shall devote most of my time to explain what we intend and hope to do in that. First I should say that we have started institutional care. We are trying to get the best people in the United States to help us to put our program into operation. We are going to the medical profession, to people known and respected in the profession for that help, to improve our institutional care by getting attending staffs from the community, from schools near our hospitals.

We are most fortunate in having a man come with us whom you all know, and whom you all respect. I just want to tell you that Dr. Paul Magnuson of Chicago is giving up his practice and for a mere pittance is coming full time in our office in Washington to organize the institutional care of the veteran. Dr. Paul Magnuson is here, and I wish to introduce him.

Now we have people like this who make such sacrifices in the interest not only of the veteran, but in the interest of the medical profession. I think we are going to succeed if we are not stimulated by personal local interests commonly known as politics. The people, on the whole, I think, have been educated rather badly in the care of the veteran, and I sometimes feel that the pressure is brought upon us to build veterans' hospitals much the same as it is to build post offices. That has got to be discouraged. We can only put veterans' hospitals where we can get high-class medical assistance on part-time bases from the outside.

Now let us get to the problem. I think you are more interested in this one than institutional care, which is the out-patient problem. At the moment all women veterans are entitled to out-patient care at whatever expense for any disability, service-connected or not service-connected. Men veterans are entitled to out-patient care only for service-connected disability. This introduces an administrative problem in the determination as to whether or not a man going for out-patient care is entitled to it at government expense. However, that is not an insurmountable problem and can be solved in many ways. It can be solved by the ordinary identification card which can be issued to each veteran, and without proclaiming publicly, a code number of disabilities can be used and he can display the card when he comes in. It will show the disability if service-connected and the doctor can look after him with some assurance on his pay.

We don't want to have the veteran treated in any way as a class apart from society. He is a part of society and insofar as possible he should get his medical care just as any other member of society in the United States gets his medical care. In the past it has been customary to designate one, usually, or two physicians in the community, as Veterans' Administration physicians. All veterans are forced to go to them. Now there are many exceptions to this rule but in many places the men who either have been recommended by the local society for this position, or who have accepted the position, are men who have plenty of time on their hands and to whom not many other people in the community are going. We should like to reverse that. We should like to have every physician in each community designated as a veterans' physician and we should like insofar as possible for the veteran to choose his own physician in his own community like any other person in the community does.

How are we going to work that out? I don't know how many counties there are in the United States, three thousand or something. The problem may have to be worked out in three thousand different ways. Each county has its own problems — has its own medical problems — and we are not interested in demanding but one plan. We will subscribe to three thousand different plans. We will make the shoe fit the foot of the county society.

I want to tell you of our start and we have made a start. The Monmouth County New Jersey Medical Society last May, submitted a

Presented at Public Relations Conference Council on Medical Service and Public Relations, October 19-20, 1945.

plan whereby, as a county society, they would give out-patient care to the veteran. They would establish an out-patient clinic. The clinic would be staffed with various specialists one night a week, or two nights a week, but would be kept open all the time with somebody in attendance for the veteran to come to in an emergency. They would have regular meetings of a rather special staff. They would make the contact with the local regional officers of the Veterans' Administration and would establish the service connection. In cases that are not service-connected these people say, "Well they are a responsibility of the community. If the government pays for them we are no worse off than any person who walks into the office. We send them a bill and if they pay we get paid." It is the same proposition as any patient who walks into a doctor's office. They have arranged with all the hospitals in the county to furnish the physical arrangement for the out-patient service, the necessary space, and the equipment. The fees to be paid are a subject to be discussed between us, and I shall take up fees in a minute. For some curious reason this proposal of last May was turned down, and shortly after I went with the Veterans' Administration, about six weeks ago, I heard about it. I immediately telephoned the president of the society and asked if their enthusiasm had been dampened, if they were willing to reopen the subject. Fortunately for the Veterans' Administration they were. They came down to Washington and laid out the plan. There were a few things which under the law we couldn't do but which we adjusted to the satisfaction of both sides.

There was one part of their proposal I thought was extremely unfair to them and that was they were going to operate this thing three months without any expense to the government except the fees paid to the physician. No expense to the government for clerical help, etc. They wanted to make a trial run, establish how much it was going to cost, how much the government ought to pay. They insisted upon the trial run being made at their own expense which was a most generous offer and that they insisted upon.

Now as to fees. We could no more set a scale of fees in Washington which would be applicable to every community in the United States than we could set a scale of prices for meals to be applicable in every restaurant in the United States and we don't intend to do it. We don't intend to publish our scale of fees. We told the Monmouth County, "You put in a scale of fees you think is fair and equitable to your own people, remembering only one thing — there are many times when a doctor does charge a fee but does not get it. The Government wants to pay as much as is reasonably justified. We don't want to beat the doctor down at all. At the same time we don't think we are in a sound position if we pay the top prices he gets from his wealthiest patients, but you submit us a scale of fees for Monmouth County and we are not going to have much argument about it."

That is for Monmouth County. If we go into metropolitan New York we pay a different scale of fees. Obviously the scale of fees varies with communities and we are going to have no set scale.

The next thing that frightens many people about having anything to do with the Veterans' Administration is the terrific amount of administrative work the doctor has to do. What he does for the patient is the least of his work. He has interminable forms to fill out. In the first place we are going to try to simplify these forms. You must remember that these are pensionable cases, and the government does have to have some permanent record of what is wrong with a man. That does not have to be as voluminous as it is now, but we do have to have a record. Furthermore, anybody who draws pay from the government has to sign something once a month, or every time he submits a fee, somebody has to fill out a form. Our position is that since the Veterans' Administration requires all this over and above medical care, the Veterans' Administration should furnish the clerical help to do it. And if we establish an out-patient clinic in any town we shall put clerical help in there to fill out the doctor's vouchers for his charges. They will also be available to write up the medical history of the case from his notes on the case, taking away from the doctor any necessity for doing all of this administrative work.

We have only made a start in one county. We hope that the news gets around to other counties because it is essentially a local arrangement.

Conditions vary so widely in different parts of the country. We will submit a plan to the thirteen districts when we decentralize. The local regional man will be given authority to deal with local societies, to advise them as to what kind of a plan will meet the requirements of the law and we will get them approved as rapidly as possible, and we would like to see them in operation.

In conclusion I want to say that in the interest of the veteran, and the interest of the people of the country, we want this care of the veteran to be done by a free and unregimented profession. We want to preserve the structure of medicine in this country. We want the minimum of government supervision of the care of the veteran. We are willing to rely on the large picture for the honest effort of the profession as a profession and we feel, — and perhaps it is apropos here with the discussion which is before you in the nature of Public Relations, — that we are contributing something to the medical profession in giving them an opportunity at no great sacrifice.

THROMBOSIS OF THE DEEP VEINS OF THE LOWER EXTREMITIES

David I. Abramson, Major, M.C.

The subject of thrombosis of the deep veins of the lower extremities can be divided into two categories, depending on whether or not the intima of the vessel at the site of the clot is involved in the process. In one type, thrombophlebitis, there is definite inflammatory reaction of the intima in contact with the thrombus, and the latter is firmly attached to the wall. In the other, phlebothrombosis, a clot is present in the lumen of the vessel, which, at least at the beginning, is loosely attached to an apparently normal wall. However, it is conceivable that with continued irritation of the intima by the clot, even a simple thrombus may ultimately be associated with a local phlebitis of the vein. Phlebothrombosis is a source of easily detached pulmonary emboli, but causes little venous obstruction, while thrombophlebitis is rarely followed by pulmonary emboli, but almost always produces venous obstruction and swelling of the limb. A distinction between phlebothrombosis and thrombophlebitis, therefore, is imperative from the point of view of treatment and prognosis[1].

Thrombosis of the deep veins of the extremities may occur not only following an operation or an injury but also during the course of a serious illness. The one factor that is common to all of these conditions is a period of confinement to bed. It is this state, rather than the initial one causing the period of bed rest, which predisposes to the formation of a thrombus. Whether the precipitating mechanism is stasis of blood in the venous bed, changes within the blood itself leading to increased tendency to intravascular clotting, injury to the vessel wall, or a combination of any or all of these factors, is not definitely known.

SIGNS AND SYMPTOMS

Phlebothrombosis — In the case of phlebothrombosis, the thrombus may begin anywhere in the deep vessels of the lower extremities, but it has been shown recently that it occurs most frequently in the venous plexuses of the calf and, to a less extent, of the foot ([2, 3, 4]). Large, fatal pulmonary emboli may arise in these sites, or the soft thrombus may grow in the slowly moving current and eventually propagate into the common femoral or even into the iliac vein. From clots in the latter regions, many small fragments may break up and cause repeated infarctions in the lungs.

As a rule, phlebothrombosis of the lower extremities is clinically difficult to recognize, and may not, in fact, be diagnosed until embolic phenomena appear. Often there are no local symptoms or only moderate pain in the calf and usually no general signs of inflammation, such as a rise in temperature or a chill. Swelling is absent or minimal. Frequently there is an unexplained elevation of pulse rate, out of proportion to other findings, and an increase in the sedimentation rate. A very important sign in the diagnosis of phlebothrombosis is discomfort in the back of the calf on forced dorsiflexion of the foot, a test commonly known as the dorsiflexion sign of Homans. Associated with this finding may be tenderness of the sole of the foot and some degree of fullness and tension of the calf muscles. Therefore, any complaints of this type, on the part of a patient who has been in

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bed even for a few days, should be given real significance by the physician, and the possibility of a thrombosis of the deep veins of the lower extremities should be considered.

Thrombophlebitis — Deep thrombophlebitis can, in most instances, be readily differentiated from phlebothrombosis. The veins of the calf muscles are rarely involved, and the process is more often present in the large deep veins of the leg and thigh. The pathology consists of a phlebitis, together with a periphlebitis and possibly perilymphatic involvement.

The attack may be initiated by a chill, elevated body temperature, and swelling, cyanosis and severe pain in the affected extremity. These findings are in contrast with the clinical picture of phlebothrombosis, in which the course of the disease may at first appear quite benign. Frequently the initial symptoms of thrombophlebitis consist of tenderness in the groin and edema of the thigh. These findings generally signify the presence of a clot in the common femoral vein. In other instances, the pain and swelling are limited to the leg, indicating that the process has not extended as far proximally.

TREATMENT

The therapy of phlebothrombosis and thrombophlebitis is in many respects quite similar and can be divided into two stages, namely, prevention and actual treatment of the condition.

Prophylaxis — Mechanical procedures: Inasmuch as the greatest single factor favoring thrombus formation in the lower extremities is inactivity and recumbency of a previously ambulatory person, the problem in great part consists of counteracting the resulting slowed venous circulation. In this respect, during the entire period that the patient is in bed, planned and supervised frequent voluntary movements of the legs, preferably against resistance, should be an important part of the program. Since thrombosis of the deep veins has been reported to occur within three days after the beginning of a period of confinement[3], these exercises should be started as soon as it is reasonably safe to do so. It is well known that any type of local exercises of the muscles in the legs will favor the return of blood to the heart through the pumping action of these muscles on the thin-walled veins. The second point of importance is avoidance of mechanical obstruction to venous return, such as might result from placing pillows under the knees for any period of time, or from having the patient in Fowler's position. These procedures accentuate the interference with venous return, which to some extent normally exists in the popliteal space, as a result of the anatomic relationship of the various structures in this region. The practice of repeated deep breathing definitely helps in the maintenance of a normal negative pressure within the chest and thus accelerates the flow of blood from the lower extremities into the abdomen and finally into the heart. A similar result is produced by elevation of the foot of the bed. Application of heat to the abdomen, producing indirect vasodilation of the vessels of the lower extremities, is of value in counteracting a slowed venous circulation. Finally, the modern trend of early rising after operation, and a shortening of confinement to bed of medical patients, through the use of chemotherapy and penicillin, contribute significantly to the prevention and the elimination of thrombus formation.

Anticoagulants: It has been shown[5, 6] that there is a definite tendency for individuals with a history of phlebothrombosis, followed by pulmonary emboli, or thrombophlebitis to have recurrences of these conditions, when exposed to situations which are conducive to the formation of venous thrombosis. This is particularly true following extensive tissue trauma or when there is involvement of the cardiovascular system and a resultant slowing of the venous circulation. Therefore, it is a wise policy to administer an anticoagulant, such as dicumarol, to all patients with this type of history shortly after a surgical procedure. Since the rationale, indications, and contraindications for the use of anticoagulants will be discussed in the section on the treatment of the acute stage of venous thrombosis, it is only necessary at this point to mention the possible complication of wound bleeding with such a program. For this reason, the administration of dicumarol is begun three days postoperatively. Actually, because of approximately a two-day delayed action (see below), its effect on reducing coagulation, under such a plan, will be manifested around the fifth day postoperatively. By this time, the possibility of wound bleeding will be minimal. In this respect, it is the opinion of some workers[7] that the risk of bleeding has

been overemphasized, and furthermore, that the incidence is very small among those patients who have already demonstrated a tendency to thrombosis. However, in the case of postpartum venous thrombosis and pulmonary embolism, special precautions must be taken because of the increased risk of bleeding from the uterus. The drug should not be administered before the eighth postpartum day and not unless the uterus is normally involuted[8].

Therapy in the Acute Stage — In the treatment of the acute stage of phlebothrombosis and thrombophlebitis, no unanimity of opinion exists. For practical purposes, the types of therapy can be divided into two groups, namely, conservative and radical measures.

Conservative Measures. *Mechanical procedures*: With respect to conservative therapy, the simplest procedure is elevation of the lower extremities. This is generally carried out immediately after the onset of the acute attack. Flexion of the hips should be avoided, and the feet should be kept higher than the face, both of which objectives can be achieved by raising the foot of the bed. This step helps to relieve the edema by favoring lymphatic flow. Heat may be applied at the same time, in the form of a heat tent or hot compresses, in order to increase the local blood supply and thus counteract the periphlebitis.

The use of compression devices, such as elastic adhesive plaster, Ace bandages, or Unna's boot, has a definite place in the treatment of thrombophlebitis. A strong and even pressure is applied with a bandage, beginning with the toes and extending to a level above the inflamed vein. The advantage of the method is that the patient can become ambulatory much sooner than with the other conservative procedures.

After the application of the compression bandage, the patient is encouraged to move his legs[9]. The possibility of dislodging a portion of the thrombus by such a procedure has been suggested, but this view does not seem to have been substantiated by clinical reports. On the contrary, prolonged immobility appears to favor extension of the thrombus beyond its fixed point in the involved vein, and, because of this, the possibility that the non-adherent portion may break off must be considered. As the signs of thrombosis disappear, exercise of the legs and thighs, preparatory to getting up, is increased. This should take the form of active flexion of the foot against resistance a number of times every hour.

Lumbar sympathetic nerve blocks: The use of sympathetic paravertebral blocks with procaine in the treatment of the acute stage of deep thrombophlebitis has recently received considerable attention[9-11]. There appear to be at least three prominent factors that produce symptoms and signs in the early stages of thrombophlebitis, namely, venospasm, coagulation, and arterial spasm, and, according to Ochsner and DeBakey[10], these are the result of the initiation of a vasomotor reflex through impulses originating in the thrombosed venous segment. It has been shown that with venospasm, venous pressure is increased, which factor favors the transudation of fluid from the vascular bed into the perivascular spaces. Because of the associated arteriolar spasm, there probably occurs a relative anoxia of the capillary endothelium, which results in an increased permeability and consequently transudation of vascular fluid[11]. Another factor which contributes to edema is the very sluggish movement of lymph which occurs in deep thrombophlebitis. The lymph vessels normally depend to a great extent upon the contractions of the contiguous arterioles and arteries for the movement of fluid within their lumen[12, 13]. Hence, in thrombophlebitis, in which arterial spasm is present, this mechanism is reduced or lacking[11]. The decrease in lymph flow causes a stagnation of tissue fluids and accumulation of proteins in the perivascular spaces. As a result, there is an increase in osmotic pressure exerted by these fluids, which prevents resorption from the perivascular spaces into the vascular tree. When the vasoconstrictor impulses are interrupted by procaine block of the sympathetic ganglions, there is produced a re-establishment of the normal exchange of intravascular and perivascular fluids and the destruction of the vicious cycle[11].

In the reported results on the use of paravertebral procaine block[9, 11], the prominent effects are the almost immediate reduction of pain in many instances and a decrease in the degree of edema. The blocks must be repeated at approximately daily intervals, since the procaine effect is only transient. Aside from the immediate relief produced by the procedure, it does not appear to have any permanent influence upon the

subsequent course of the disease. In other words, sympathetic blocks fall into the category of symptomatic treatment. However, when there are definite signs of local arterial spasm, or when there is a considerable amount of pain and swelling present, this type of procedure is indicated[14].

Anticoagulants: Another method of treatment of the acute phase of either thrombophlebitis or phlebothrombosis, which is receiving considerable attention at present, is the use of anticoagulants, such as heparin and dicumarol. Heparin interferes with the clotting mechanism, and its effect is immediate but transient. It probably acts by inhibiting the conversion of prothrombin to thrombin and by preventing the agglutination of platelets, the latter most likely through its anticoagulant action[15]. It must be given intravenously and in sufficient quantities to maintain the clotting time of the venous blood at a level between 15 and 20 minutes[16]. It may be administered either by slow, continuous drip or by intermittent injections of 50 mgs. at four-hour intervals. Heparin should be given for from three to five days and then gradually withdrawn over a two-day period. Occasionally, after sudden withdrawal, thrombosis may still occur.

Because of the high cost of heparin and the fact that its action is only transient, it has been replaced to a great extent by a new anticoagulant, dicumarol, which is the toxic principle isolated from spoiled sweet clover hay. It was first described by Link and his associates.[17]. There are certain advantages of dicumarol over heparin, in that it is effective when given by mouth, it has a prolonged action, and it is quite inexpensive. The disadvantages, on the other hand, are that the anti-clotting effect is delayed 24 hours or more, there is an increased tendency toward bleeding which persists several days after withdrawal of the drug, and daily prothrombin determinations are necessary in order to maintain the blood concentration at a therapeutic level.

Dicumarol, in as yet an unexplained fashion, reduces the quantity of circulating prothrombin. Whether this action is due to interference with the formation of prothrombin in the liver or in the alteration of its action in the blood stream is unknown. Dicumarol, therefore, is effective in preventing postoperative thrombosis and embolism and extension of an already existing thrombus, but it will not in any way dissolve a clot which is already formed.

There are numerous routines for the administration of this drug, but the one commonly used consists of the following: An initial dose of 300 mgs. is given to the patient on the first day, after determining the control prothrombin level. On the second day, 200 mgs. are administered, and this dosage or one of 100 mgs. is given on the third, if the blood prothrombin concentration has not fallen below 20 per cent, using the curve described by Quick[18]. The subsequent daily maintenance dosage will depend upon the prothrombin level for that day and is given only after the determination has been performed. The purpose of this is to keep the percentage prothrombin level around 20. If there is a drop below this point, the administration of the drug is stopped at once, to be started again only when the readings have risen beyond the desired level.

When it is necessary to have an immediate delay in intravascular clotting, as in the initial stage of phlebothrombosis or thrombophlebitis, the simultaneous use of heparin and dicumarol is advisable. Both are given initially, and then after two days, the heparin is discontinued, while the dicumarol is still administered. The latter is continued so long as the patient is in bed and for at least a week after he is up and around; the blood prothrombin level is maintained around 20 per cent during the entire period.

There are a number of contraindications to the use of dicumarol. It should not be given to patients with subacute bacterial endocarditis, in whom there is already a natural tendency toward hematuria and central nervous system bleeding, or to those with renal insufficiency, especially with urinary suppression, since there will be an exaggerated response to the drug, due to the fact that very little is being excreted. For obvious reasons, patients with blood dyscrasias and a tendency toward bleeding should not receive dicumarol, and also those with liver damage and a vitamin K deficiency, since in the latter state the prothrombin concentration is already reduced and hence is difficult to restore. The drug should be given cautiously in the case of ulcerating and granulating lesions, in dietary or nutritional deficiency, or in the presence of vomiting due to gastric or intestinal obstruction[7].

Recently it has been found that menadione

bisulfite (synthetic vitamin K), injected intravenously in 60 mgs. doses, will counteract a marked fall in prothrombin level[7, 19, 20]. This procedure has helped materially to reduce the possibility of serious bleeding with the use of dicumarol. Transfusions of fresh citrated blood have also been utilized for this purpose.

Radical therapy. In most instances, the conservative measures described above are sufficient to treat the acute stage of deep thrombophlebitis. However, on occasion it is necessary to resort to more radical procedures, as for example, in the case of suppurative thrombophlebitis following puerperal sepis and other infections. In patients with such conditions, ligation of the involved vein above the level of the process is imperative, combined with the use of chemotherapy.

In the case of phlebothrombosis, in which pulmonary emoblization is a relatively frequent complication, some investigators[21–25] advise proximal ligation and division of the involved vein as the procedure of choice. This is performed when the clot in the vein has not as yet extended upward as far as the inguinal ligament. It appears that division of the superficial femoral rather than the common femoral is preferable, since the period of postoperative swelling is shorter. However, the possibility that the common femoral vein may still act as a site for embolus formation exists under such a plan.

According to the advocates of vein ligation, when propagation of the thrombus has taken place beyond the level of the inguinal ligament, thrombectomy should be performed. It is felt that removal of the thrombus is of value not only because it prevents the occurrence of emboli, but because the presence of a clot in the venous segment acts as a focus for the production of reflex vasospasm in the involved extremity. This point has already been mentioned with respect to the use of paravertebral blocks. It is the general opinion that after thrombectomy the vein should be ligated, and this has been performed even in the case of the inferior vena cava under certain circumstances. It has also been suggested[21, 25] that, in patients more than forty years of age, ligation of the iliac or femoral veins not only on the side of obvious thrombosis but also on the contralateral extremity is indicated, in order to eliminate a possible focus of embolus formation in the latter site.

The possibility still exists, however, that with all these surgical procedures, a thrombus may form proximal to the ligation, which may be the source of pulmonary emboli. It may, therefore, be necessary to supplement these methods with anticoagulant therapy. It is the opinion of some workers that in certain instances in which radical surgical treatment has been carried out, the same results could have been obtained by conservative measures. Furthermore, it must be kept in mind that if ligation of the common femoral vein is performed, such a procedure may result in a state of chronic venous insufficiency which may exist for a long period of time.

SEQUELAE OF THROMBOSIS OF DEEP VEINS

In the case of phlebothrombosis, after the dangers of the acute stage have passed and the signs and symptoms have disappeared, there are generally few sequelae to observe. At times, some edema persists, and this may be treated with a well-fitting elastic stocking.

With respect to thrombophlebitis, however, in many instances the sequelae may be incapacitating and may persist for many years. The most common findings are post-phlebitic edema and signs of vasospasm. More rarely varicosities and ulcerations will result.

Post-phlebitic edema: The edema of the extremity, which almost invariably follows the acute stage of thrombophlebitis and which at times may be quite marked, has been attributed to a number of factors Among these are interference with venous return and lymph stasis, the latter resulting from an associated involvement of the lymph channels subsequent to the perivenous inflammatory reaction[26]. It has been found that in most instances complete rest in bed with the extremity elevated for a period ranging from two to five days will reduce the swelling to a minimum. Then the patient is given a well-fitting elastic stocking and is warned not to get out of bed without wearing it. He generally has to continue doing this for at least a year after the acute stage. By that time, sufficient collateral venous vessels may be formed to take over the circulation previously carried on by the thrombosed vein. In some instances, however, this occurs only after many years. Recently, mecholyl by iontophoresis has been used in cases of post-

phlebitic edema which does not respond to the usual methods of treatment, and the results in some instances have been encouraging[27].

Lymphedema: If venous and capillary stasis is not controlled, eventually increased capillary permeability follows, with the accumulation of a protein-rich fluid in the subcutaneous tissues. Ultimately there will be a response to this in the form of fibroblastic infiltration, resulting in obstruction of lymph channels and the formation of lymphedema[28]. When the condition has progressed to this stage, little in the way of conservative therapy is effective. An elastic stocking, however, should be tried.

Dilated and varicose veins: It is a fairly common finding to observe dilated superficial veins following acute thrombophlebitis. This is probably due to the fact that, in view of the occlusion of the deep veins, the venous circulation is shunted, to some extent,through the superficial vessels. If this continues, the latter may become dilated to the point where the valves are no longer competent and then varicosities will form. The production of incompetency of the deep veins, as a result of involvement of their valves in the thrombophlebitic process, also leads to a greater load being thrown on the superficial venous system. Following the subsidence of the acute stage, these valves are left scarred and shortened[29]. The use of an elastic stocking may help counteract the tendency to formation of the superficial varicosities.

Ulcers: Ulcers of the skin are a more serious consequence of thrombophlebitis. These may follow a minor injury to an extremity, previously the site of such a process, and in which there is definite venostasis. The ulcers are generally present in the lower portion of the leg. Various treatments have been suggested. Some are simple and consist chiefly of elevating the leg, with the patient at complete bed rest, and applying either pressure bandages or the Unna's paste boot; at the same time, any infection which is present is treated with chemotherapy or by other means. This procedure may frequently be successful. If the ulcer is indolent, it may be necessary to remove a considerable portion of the tissue surgically and resort to skin grafting. Mecholyl by iontophoresis has been used with varying degrees of success[27, 30, 31], and in some instances, if complete healing does not take place, the procedure does improve the ulcer sufficiently to make surgery safer. If there are varicose veins present, which are contributing to the stasis in the vicinity of the ulcer, it may be necessary to ligate these.

Vasospasm: Another sequela of thrombophlebitis manifests itself in the form of excessive sympathetic tone. The extremity is cold and blue and shows at times incapacitating hyperhidrosis. These findings may or may not be associated with edema. Although they can all be eliminated by means of a lumbar sympathectomy, only infrequently is this surgical procedure warranted. In most instances, the signs of excessive vasospasm gradually decrease in intensity with renewed physical activity and time.

Night cramps and muscle pains: Patients with a history of deep thrombophlebitis may complain of night cramps of such intensity as to awaken them from their sleep. These are generally present subsequent to a full day's activity. It has been found that in some of these individuals the use of quinine at bed-time will counteract the symptoms, if only temporarily.

Some patients will complain of pain in the calf muscles with activity, which is at times indistinguishable from true intermittent claudication. The basis for this pain is not clear, although it is probably in some way related to the stasis of blood that exists in the vascular tree of the lower extremity, following thrombophlebitis of important deep veins.

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THE GANSER SYNDROME

A Case Study

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This syndrome has from its earliest description in 1897 by Ganser[1] continued to confront psychiatric thought with a most intriguing as well as baffling subject for discussion. From the available literature it seems also evident that the classical syndrome has become less frequent in its pure form so that today it can be looked upon only as a symptom complex engrafted upon or portending one of a variety of nervous or mental disorders. Ganser referred to a "specific hysterical twilight state, the chief symptom of which was 'talking past the point' (Vorbeireden)." He noted this syndrome in prisoners on remand, where the value of simulation to avoid punishment was obvious. Invariably every one of his patients demonstrated hallucinatory experiences so influencing his conduct as to result in violence; many showed a generalized anaelgesia.

The recent experience of Stern and Whiles[2] (1942) submits that the syndrome is quite rare elsewhere than in prisoners and suggests its origin "in people, who, although mentally deranged and not realizing this, wish to appear so to the popular mind, persons suffering mental illness are characterized by an extreme simplicity and the patient actually simulates illness by foolish responses to interrogation, which nevertheless, indicate they had perfectly well understood the nature of the questions." On the other hand, Ricklin (1940) found it more common in non-criminal cases and believed it was due to repression of painful experiences. Most authors hence agree that an underlying motive exists for the patient and secondary gain is achieved by utilization of the Ganser symptom.

From the descriptive standpoint, Noyes[3] has perhaps most clearly defined the syndrome as a "combination of instinctive, rational purposeful and deceptive elements, and theatrical behavior representing a crude, hysterical tendency allied both to simulation and to hysterical dream states. The patient is usually in a situation which would be solved or mitigated by irresponsibility (probably not consciously acknowledged)

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and accordingly without being aware of it, actually develops mental disturbance."

More serious difficulties are encountered in an evaluation from the diagnostic standpoint and in an attempt to understand the underlying mechanisms operating in all spheres of conscious and subconscious awareness. Various interesting speculations have been proposed by leading psychiatrists. Noyes calls it an hysterical reaction in which the circumstances are such that the advantages to be gained by a mental disability are greater than by physical disorders. Ganser implied a dimming of consciousness. Bleuler[4] (1937) maintained this was an acute syndrome based upon a chronic schizophrenia. In the vast experience of William A. White[5], he was led to believe it was characteristic of states of psychopathic inferiority.

Wernicke earlier described a state of "hysterical pseudo-dementia" observed in one case of acute hallucinatory paranoid state and among the residuals of such a condition (probably alcoholic in origin) in another. Finally Anderson and Mallinson[6], in discussing the "syndrome of approximate answers" insist upon the difficulty sustaining speech at rapid random unless promulgated by a severe schizophrenic thought disorder; to simulate the popular lay concept of the insane talking nonsense is difficult, hence the Ganser case employs the 'approximate answer' response.

The case to be described contains features of the hysteriform, the epileptiform, the alcoholic and the diffuse organic disorder and on this account is deemed worthy of recording.

PROTOCOL

CASE: W. K., age 39, of Polish ancestry; one brother committed suicide; mother died at 47 and said to have suffered "insane spells". The patient was native born, birth and early development were not remarkable; discontinued school in the third grade to assist on the farm. Lifetime occupation as farmer; remained single. Since the age of 22 had been addicted to the excessive use of alcohol and incarcerated in jails on many occasions because of disorderly conduct. Latterly, the patient had suffered transient episodes of fearful hallucinations related to heavy drinking. On one occasion in 1938, he developed the delusion that he was receiving telepathic messages by short wave, the latter disappearing when sober. In 1942 he entered the Norfolk State Hospital and was later discharged as without psychosis, chronic alcoholism. A few months later at a sanity hearing held in Nebraska, a physician had diagnosed him as "beginning Dementia Praecox; was quarrelsome when drinking and displayed homicidal tendencies."

Unfortunately, no further anamnestic data is available in this case. While he resided his lifetime in Nebraska, he was apprehended in January, 1943, as a transient in upper Illinois unable to identify himself, prowling about the city seemingly oblivious of his surroundings, and "willfully guilty of open lewdness and disorderly conduct tending to debauch the public morals." For the ensuing six months, he was confined to a county jail and was then committed to the Elgin State Hospital in July, 1943.

Physical Examination: revealed a well-developed male of athletic habitus; B.P. 96/56, no remarkable neurological findings and normal ocular fundi. Fluoroscopy of chest, blood counts, and urine examination were without abnormalities. Spinal fluid contained one cell, negative Ross Jones, Wassermann and Pandy, total protein of 27 mgm. 100 c.c., and colloidal gold sol curve of 1111100000. Electroencephalography revealed a most peculiar wave formation that could not be accurately classified, yet seemed to be related to the petit mal variety of cortical dysrhythmia. Pneumoencephalography was performed by intrathecal injection of 100 c.c. of air and revealed a normal filling of the ventricular system.

Mental Examination: At the outset he was cooperative, coherently related having been alcoholic for years, and showed moderate awareness of his present situation; within a week, however, a decided transformation in personality became apparent.

He greeted me in a polite manner but throughout the conversation appeared to be placid, at times semi-stuporous. At several points he seemed perplexed and when this occurred he would often give up completely the attempt to explain or elaborate. At times he appeared seclusive and suspicious but it was hard to distinguish these attitudes from the apathy which marked his general behavior. This vagueness, apathy and disorientation were apparent at several different times. He gave as the cause of his being at this hospital the fact that he was picked up by a detective about two weeks ago outside the Army camp where he had been stationed. He knew this camp was near South Chicago but he did not know the name of it. He believed he was arrested for being outside the camp after hours but he was not clear as to whether he was leaving or entering the camp. He said that he had lost his way but he was unable to explain how this had happened. When asked if he had been in uniform when arrested, he replied in the negative but was unable to explain this paradox. Finally he said that he had been on leave and so did not have to be in uniform. According to his account, he had been brought to a police station and after a review of his case had been sent here. He was either unable or unwilling to give any explicit reasons as to why he had been hospitalized. He said he had been in the Army about 10 months and had no complaints to make against Army life. However, he did say he would rather be in the Navy and that he intended to enlist in the Navy when he left this hos-

pital. He did not seem to think that the present difficulty would be any obstacle to this. (This entire story is evidently confabulated, has never been substantiated and is negated by finger print analysis that proved he had never been admitted to the Armed Forces.) When asked if he knew what kind of an institution he was in, he said "no", and when told it was a mental hospital, he seemed mildly surprised. He said that he would like to do some work around the hospital, that he had worked in a hospital before as a helper in a kitchen, but was unable to name the hospital. When asked if he had been a patient, he said, "Not exactly. I was a helper." Although hallucinations were not elicited and he did not believe that he suffered a mental disorder, he seemed disoriented as to events in the immediate past, especially as to those leading up to his hospitalization. His adjustment to the ward situation was one of marked passivity and apparent indifference; yet on a number of occasions when the opportunities presented themselves, he made unsuccessful attempts to escape. When confined to a ward for closer supervision, he was disposed to remain either confined to bed throughout the entire day or to stand about in one favored location with head bowed upon his chest, prayerful and statuesque.

During the formal mental interview the patient maintained a rather amused smile and showed awareness of his surroundings; spontaneously asked for a cigarette in a carefree and adequate manner but otherwise did not seem well disposed to respond to questions. On sporadic occasions he could be stimulated to smile and respond normally to the presentation of a humorous story. This however was obtained only through a subtle manoeuver, since for the most part he remained evasive, tended to block and responded to all questions in an approximate manner. When pertinent questions bearing upon his exact identity were abruptly posed, he seemed unable to offer an approximate response and feigned stupidity, at times answering in an echolalic manner; when further pressed, however, a more approximate answer could be elicited. In addition to the manifestation of apparent dysphasia, there was also a complete right-left body image disorientation. He gave the date as June or July 25, then August, somewhere 1933 or 1934 (actual date was July 20, 1943); unable to identify nature of surroundings, agreed it may or may not be a hospital; states he has been here 3-4 weeks (actually 5) and could not recall where he came from, thought he came by bus from somewhere, several men were along, didn't bother to ask where he was going; did not recall admission routine, was unfamiliar with ward or medical personnel; retentive memory capacity seems intact, recalled examiner's name after 15 minutes. To most responses concerning early life and subsequent development, he answered, "I don't know," or "I don't remember". Guessed he had a mother and probably must have had a father — whether alive or dead he did not know. Very agreeably admitted the possibility that he might be out of his mind. When informed that he might have to remain here forever, he stated, "You're the doctor, did the transfer fall out of here?" Parried questions, echolalic and perseverating; nodded in agreement and smiled when threatened with being locked up forever. At this point however one sensed an underlying current of resentment, after which "I don't know" became the stock answer. He later insisted that he had been in the Army for two years but he was unable to recall the name of the Camp or the State, inquiring, "What State is this?" When urged further, believed he was discharged because of a bad heart and impaired vision. Denied alcoholism and venereal infections. With regard to number of children at home, wife, parents, etc., he made no venture at guesses; either he was wily and shrewd in avoiding subtle questioning, to serve his purpose, or he was incapable of recall. "I'm just like the rest of them, people, don't know where I'm at or why. It seems to me I've seen you somewhere before. Your face is very familiar." He stated that many here looked very much as if he had seen and known them years before (deja vu) "a lot of M.P.'s." Various articles were tested for agnosia; a matchbox placed in the palm was first labeled dynamite, then paper; when permitted to see it, called it a KITE (actual description on the matchbox was LITE KING), referred to match as 'streich holz'. Referred to pencil placed in palm as a fountain pen, did not name it visually, referred to it as yellow, then wood, red (for eraser) and did not elaborate its purpose. When later given pencil and paper, proceeded quickly to write his name. 3 plus 2 equals 6; 4 plus 3 equals 5; 2 plus 1 equals 7; when asked to write 5 plus 2, writes 5 times 2 equals 0, verbally stated 5 plus 2 equals 9; 3 plus 6 equals 12; 5 plus 2 equals 9; 3 plus 2 equals 8; 3 plus 6 equals 7; 5 plus 2 equals 13. Gave the months as January, February, March, April, July, September, November, January, December, September, November. Wrote his name properly, read written material in a manner remotely resembling the actual words. The alphabet was given as A B D C E H G S R T L E (verbal). He did not decipher what he had written and could not comprehend the most insulting remarks on paper. Finally he was unable to read numbers, referred to them as a "mark". Showed no emotional reaction to insulting verbal language. Showed complete right-left disorientation, raised left arm for right arm on command. Very beautifully did just the opposite to what was required in single execution of act; when two component acts were involved, one was correct, the other invariably reversed. Occasionally a complex act was entirely reversed. Referred to handkerchief as cloth, the electric fan as wind charger; called a 5c piece a dime, 2 nickels total 50c; identified all primary colors wrongly and called a white shirt green.

Sodium Amytal, gr. 3¼, was administered intravenously, wherupon he suddenly became animated and smiled broadly; admitted drinking alcohol excessively; gave the date correctly, name and purpose of hospital correctly; now identified pencil and matchbox, but was still unable to perform simple arithmetical problems entirely too well — many responses were cor-

rect, however. Named the months correctly and rapidly; A B C's were rattled off. Recalled having heard radio voices coming from the mattresses, wall and the light — these were quite real to him, "They're trying to test me out, training, etc. — most people get that. You take that fan or radiator, a voice could come out of there; you know radios are now made as small as a shell. I wasn't frightened." (Denied visual hallucinatory experiences.) "Everything is possible nowadays, pencils, pens, cigars, etc." After a period of 25 minutes, he returned to the previous performance: 2 plus 3 equals 6; 4 plus 5 equals 7. "It's pitiful nowadays the way things are going, the way people look and act."

A cursory investigation with the psychogalvanometer revealed wide fluctuations in skin resistance almost invariably in response to leading questions suggestive of "escape" from some as yet undefined situation. On still another occasion, a similar positive response was obtained when accused of simulating mental illness; the accompanying affect at this time was an evident silliness and facetiousness. Later intensive treatment with Faradic stimulation did not in the least succeed in altering the quality of verbal responses; actually one might say that the form of mental response was aggravated and the quality of thinking became more confused.

Subsequent Course: During the ensuing nine months, the course was one of progressive and rapid deterioration punctuated by periods of explosive impulsivity, window-breaking, urinary incontinence and aggressive destructive behavior necessitating physical and chemical restraint. At other times he was apathetic, grinning, mute and dilapidated in manner. At present he is in the "yes and no" stage of verbal response not in the least modified by intravenous sodium amytal exploration. The present mental picture is of the crude, primitive quality observed in one severely deteriorated.

DISCUSSION

The syndrome of approximate answers has continued throughout the experience of psychiatry to remain unclear as to the qualitative nature of this peculiar reaction type and as to the dynamic meaning of this symptom both to patient and observer. Dynamic psychiatry can neither be content to regard the Ganser state as appearing exclusively in the prisoner about to be tried nor rely upon the convenient use of the term "repression of painful experiences." That it is a specific psychological modality available to the patient for use (in the psycho-physiological sense in an attempt at homeostasis) seems more probable. Can this represent a preformed level of thinking, perhaps preconditioned, existing in everyone and utilized as a transient, albeit drastic attempt on the part of the patient in an attempt at reorganization? Clinical experience would seem to support this contention. Often enough one witnesses theatrical and ludicrous behavior in the early hours or days of an acute mental excitement, soon relinquished and replaced by the more typical features of the particular psychosis. Does this initial "acting out in the dramatic or silly manner" not seem to symbolize the patient's conscious effort to negate from awareness the seriousness of his developing mental illness? All face-saving employment of 'noblesse oblige' must therefore help the patient to deceive not only others but himself. Children often employ the ludicrous or approximate answers in order to attract desired attention or evade responsibilities. The author submits that this syndrome is psycho-physiologically available to all individuals and is neither infrequent nor as pathognomonic of one psychiatric syndrome as formerly supposed. The paralogia of schizophrenia would seem to spring from a closely allied if not identical source. The suggestion is made that keen attention to the earliest hours or days of a developing mental illness may reveal a higher incidence of Ganser-quality of response and behavior.

In our patient, the Ganser syndrome was utilized on the preconscious level until either exhausted (in the physiological sense), or no longer available, followed by regression to lower and more primitive levels. In the diagnostic sphere, the differential diagnosis rests between a chronic schizophrenic thought disorder and a diffuse organic brain disease. More exact discrimination is not only difficult to achieve but only of secondary importance. The electroencephalographic dysrhythmia may represent an underlying organic brain disorder. Our patient has gone on to advanced deterioration in the broadest aspects.

CONCLUSIONS

1. A case study is presented illustrating the Ganser syndrome in the classical form, eventuating in far advanced deterioration.

2. The relative infrequency of this syndrome and closely allied mental behavior is questioned.

3. The syndrome would appear to represent a psycho-physiological regression to the preconscious level, available to all patients entering upon mental illness, and utilized as a drastic attempt at self-reorganization. The theatrical and self-deceptive qualities seem to be intended

both for the observer and the patient in whom the need arises to negate from awareness a developing mental illness.

4. Keen attention to the earliest hours and days of a developing mental disorder will undoubtedly disclose a higher frequency of the Ganser or Ganser-like symptom complex.

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DISCUSSION

Dr. D. B. Rotman, Chicago: I think Dr. Lieberman is to be commended for his excellent case study. He is to be commended more particularly because of his courage. There is hardly any mental syndrome that that has been so erroneously misinterpreted as the Ganser syndrome. Originally it was considered as something to be found exclusively in the hysterical states. Why the Ganser syndrome should be so misunderstood has never been clear to my mind but it does seem that every one tries to talk about the Ganser syndrome in somewhat mystical terms. The Dammerzustard, thought to be a prerequisite background for the Ganser, seems to me to be shared by the investigators as well as those who suffer from it.

My earliest and first experience with the Ganser syndrome was at Ann Arbor, Michigan, where I was fortunate in World War I to be sent for a course in training with Dr. Barrett. He had a card on which he had about 50 pertinent syndromes that were to be checked off in each case. It seemed to me that if Barrett thought that the Ganser syndrome occurred frequently enough to be included in his stock card, it could not be the mysterious thing it is made out to be.

The other point about the Ganser syndrome has been that it has been more or less connected up with malingerers. Even our essayist has tried to bring out that point and tried to emphasize the fact that it was not a syndrome necessarily to be found in persons under criminal trial. If this symptom were something peculiar to criminal thinking I do not think Barrett would have included it in his stock questions to be noted about his mine-run psychiatric patients.

There are other points which the essayist has brought out not so much in relation to his own cases, but he had one which he skipped over very quickly, namely the Ganser syndrome is something that is noted in children who wish to attract attention or evade responsibility. We are I think fortunate in having the work of Dr. Ralph Hamill who has done many years of research into the verbal production of children. He has gathered much evidence to show that almost every conversation which the child indulges in partakes of the feigning and theatrical. This tendency to answer questions by approximations, he thinks, might even invalidate psychometric testing with children.

Coming to the points as to whether or not the Ganser syndrome found in organic brain disease, I think the most elucidating thing about the case presentation by Dr. Lieberman is the fact that at one time sodium amytal was able to dispel the Ganser syndrome, and bring forth answers that were fairly accurate, but as the organic phase advanced, sodium amytal was not able to do that. That is in keeping with the recent observations that Dr. Roy Grinker has brought us back from the African battle front. He says that sodium pentatol cleared up hysterical cases developed actually at the battle front and failed to do so in organically traumatized cases. He thinks that a differentiation can be made on the basis of the reaction to pentatol, which is exactly what Dr. Lieberman has found.

In conclusion, I wish to state the attempt to artificially separate organic from functional brain conditions was long ago exploded by Orton when he pointed out the similarity between the "word salad" of chronic schizophrenics and the word production of certain types of aphasia.

THE ACTION OF SHOCK THERAPY IN THE LIGHT OF CLINICAL OBSERVATION

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It is curious what a variety of reagents have influenced persons with mental disorder. The agents appear non-specific, yet the similarity of effects suggests some specific mechanism. What light does clinical observation cast on the process? We know the syndromes treated, we know something of the mechanisms at work, and we see what happens under treatment. These very items may also indicate *how* it happens and *why*.

Our data are based on electrically induced convulsive and sub-convulsive reactions; but carbon dioxide, sodium amytal, insulin and metrazol have been similarly employed. With any of these, one may see startling alterations in behavior and the content of awareness. The results

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sometimes confirm diagramatically certain current theories of mental disorder. The patient harbors, without successfully unifying, distinct and incompatible sets of attitudes. The more socially appropriate set dominated awareness during health, and surrender to a contrary set of tendencies constitutes the mental illness. Any of the agents cited may evoke an astonishing reversal of these incompatible systems in the patient's awareness, so that contradictory kinds of behavior may succeed each other in a matter of minutes. The immediate effect is temporary, and the repeated application of such agents may or may not eventuate in a more stable preponderance of the conventional or "normal" attitudes, the expected therapeutic result. These immediate reactions are readily observed and demonstrate at the outset the profound failure of integration which characterizes a psychosis.

Experience has everywhere shown that the results of treatment are correlated with the clinical disorder. The periodic affective reactions respond better than schizophrenic disorders. Acute schizophrenic states, especially with affective components, may do fairly well. Hebephrenic and paranoid reactions and certain massive catatonic states have derived little benefit. Most neuroses have shown no significant, certainly no dramatic improvement.

The outcome of treatment has thus been best in disorders with a spontaneous tendency to remission. Manic and depressive reactions, for instance, generally return to the prepsychotic state, and sometimes the patient seems to his family better than he has been for a long time. But in certain cases, despite intensive treatment, improvement is only temporary, with a persistent return to the illness rather than to health. Involutional reactions do strikingly well, yet certain older involutionals persist stubbornly in depression. Organic changes may be suspected, but can they explain the repeated observation that the depressive attitudes may be completely, if temporarily, reversed? In still other cases, the intensity of the depressive or manic behavior is diminished, yet full recovery fails to ensue. The initial treatments may be followed by dramatic relief, but when contact with certain members of the family is resumed, the symptoms recur in whole or in part. Even after extended treatment and hospitalization, some cases cling to a persistent compromise between their prepsychotic and psychotic reactions. Such persons may regain a superficial adjustment in their original situation, but pay for it by residual anxiety and limited satisfaction with life. These patients, incidentally, are generally involved in an ambivalent relation to other family members; conventional affection or tolerance coexists with strong but less conspicuous hostility.

The catatonic states exhibit an eruption into awareness of attitudes and motives beyond control or understanding by the patient's conventional self. In many such reactions, shock therapy permits the presychotic self to regain control and submerge the psychotic experiences. A few patients recover good personality function. Again, many more improve to a certain compromise level; they are not actively psychotic but are thereafter limited in human effectiveness and initiative. Some appear impervious to treatment or even deteriorate during it; this may happen despite an occasional striking but temporary restoration of the prepsychotic state. Established hebephrenic or paranoid reactions are still less favorable. Some chronic hebephrenics have shown anxiety and excitement if they responded at all. Certain tense paranoid persons experience a decrease in tension; yet chronic paranoids likewise often display increased anxiety. The paranoid ideation has not been significantly influenced.

In the few neurotic patients that have been treated, the changes have never been remarkable. If improvement occurred, it appeared related to a favorable shift in the personal situation as much as to convulsive therapy.

All these illnesses illustrate consciously unsought solutions for the presence of incompatible tendencies in the personality. Generally one group of tendencies permits satisfactory human relations, while another opposes them. In one class of disorders, the attitudes that block successful contact with people achieve a massive but unstable domination; healthful impulses may be strong, but are temporarily inhibited. Whenever the total situation is properly altered, such an illness tends to spontaneous recovery. This is the case in most manic-depressive psychoses and in a number of acute schizophrenic states. Recovery indicates a basic supremacy of the more favorable tendencies in the human situa-

tion. Precisely in these conditions, shock therapy shows the most dramatic results, in simply permitting or assisting the reemergence of the inhibited attitudes. When the total situation is unfavorable, shock therapy is relatively helpless. This seems to be the case in resistant or relapsing manic-depressives and in many schizophrenics. The latter are apt to pursue an unfavorable course despite brief resurrections of latent normal behavior. Typical examples are the chronic hebephrenic states, in which everything points to a quantative excess, in the patient and in his situation alike, of attitudes opposed to success with human beings. Again, intermediate cases are seen, in which treatment leads not to full recovery but to a state of partial restitution, a no-man's land between total health and total illness.

A different class of disorders exhibits no alternating or exclusive predominance of one set of attitudes over another. Instead, the illness reveals a more stable equilibrium, a greater *fusion*, so to speak, of the conflicting forces. This is best illustrated by paranoid reactions, in which the rationalized feeling of persecution is a compromise, and generally an unshakable compromise, between the patient's need to live successfully with other people and his inability to do so. The neuroses demonstrate similar compromise mechanisms. Such reactions are hard to influence by shock therapy.

A survey of the clinical disorders, their mechanisms and their outcome under treatment, inevitably invites correlation of the factors concerned. This correlation may be expressed in a simple hypothesis: *that the outcome of treatment in any given case is a vector sum of all the attitudes in operation for or against successful human relations.*

For example, where the illness exhibits an unstable equilibrium and the favorable tendencies predominate, the results are good (manic-depressive and certain acute schizophrenic psychoses). Where the illness is stabilized by a great preponderance of unfavorable tendencies (chronic schizophrenics) or by a deeply grounded compromise between opposing tendencies (paranoid, neurotic) the results are trivial. In short, the outcome of therapy in any case is simply a resultant of all the interpersonal tendencies concerned.

There are advantages to viewing the effects of shock treatment in this light. It is a step away from pure mythology in theory and pure empiricism in treatment. Observers have from the first emphasized that the results of shock therapy unaccompanied by psychotherapy are not satisfactory; that shock therapy in itself is merely a symptomatic measure. These observations corrobrate the hypothesis; it simply makes explicit the principle behind those observations. If any treatment is not to end in disappointment, its significance must be properly viewed in terms of the total therapeutic situation. Shock therapy is no mystical, self-sufficient technique for neutralizing a psychosis, or injecting into the personality capacities it previously lacked. Perhaps, to shift metaphors, the point can be put in terms of a poker game. Shock treatment may "call" the illness and sometimes hasten a showdown. It doesn't necessarily give the patient a better hand.

To understand this more technically: Convulsive therapy does not attack the *psychosis*, which is an interpersonal phenomenon. It attacks a *neural link* in the total chain of events. This link in the psychosis seems to be the *mechanism which selectively limits the attitudes available to consciousness.* Some such nervous system activity is personified in psychoanalysis as the Ego. At any rate, shock therapy seems to produce its effects by acting at a physiological level on the mechanism which expresses interpersonal tendencies, not on those tendencies themselves.

The abrupt and significant fluctuations in behavior evoked during treatment indicate that such a mechanism — functioning as awareness, retention and discriminative inhibition — is the physiological target of shock therapy.

Its temporary abolition or weakening by any method suspends concern with the current situation and permits the reemergence of latent or potential tendencies.

The shock procedures may accordingly initiate or facilitate clinical improvement, but it is hardly likely that they underlie or maintain it. For that, one must turn to the patient's life, of which the treatment is merely a fragment.

CONCLUSION

Observations during convulsive therapy suggest the hypotheses (1) that the outcome in any case is a resultant of all the interpersonal ten-

dencies concerned; (2) that the treatment acts on the neural mechanism which selectively expresses interpersonal attitudes, not on those attitudes themselves.

ILLINOIS PRENATAL LAW BRINGS RESULTS IN SYPHILIS CONTROL

550 Women Treated During Early Stages Of Disease Gave Birth To 518 Normal Nonsyphilitic Children

Since the enactment of the Illinois Prenatal law in 1939, a total of 1,448 pregnant women with syphilis have been treated by 1,087 private physicians, according to Herman M. Soloway, M.D., of the Illinois Department of Public Health. Out of 550 women, who were treated during the early stages of the disease, 518, or 94.31 per cent, gave birth to normal nonsyphilitic children.

Dr. Soloway explains the Illinois plan of treatment in the October 13 issue of *The Journal of the American Medical Association.* It provides for a weekly injection into the muscles of a bismuth compound throughout the term of pregnancy, and eight to 10 weekly injections into the veins of an arsenical drug, with an occasional four weeks rest period. The treatment plan is arranged so that the arsenical drug is administered in the last weeks of pregnancy.

"A very important part of the control of syphilis in pregnant women is the need to keep them under treatment throughout the pregnant period," the Chicago physician writes. Feeling that education is the answer, the author suggests that programs on all phases of the cause, spread and cure of syphilis should be carried on more intensively to insure a better understanding by and more active cooperation from the general public.

"The Illinois Prenatal law provides for the blood test to be taken by the attending physician at the time of the patient's first visit, with the intent of instituting treatment early. Yet to this day many pregnant women do not apply for medical care until very late in pregnancy or just before confinement. Then too the law does not compel a woman to take treatment if she refuses it."

The most effective results were attained with the 550 women who began their treatment before the fourth month of pregnancy. "In the 134 cases in which treatment was begun before the end of the fifth month of pregnancy there were 112 (83.58 per cent) normal nonsphyilitic children. . . ."

There were 409 syphilitic pregnant women placed under treatment after the fifth month. Of the number 207 (50.6 per cent) gave birth to normal nonsyphilitic children. The last group, 355 cases, received no treatment. Only 93 (26.48 per cent) of this group gave birth to normal nonsyphilitic children.

In explaining the Illinois law, the doctor says, it "provides that all physicians attending pregnant women must submit specimens of the patients' blood for . . . examination to a state or an approved private or hospital laboratory. In the case of a positive blood test, a copy of the report is submitted by the laboratory to the office of the Division of Venereal Disease Control. The central registry is then checked to see if the case has been reported by the physician. If it has not been reported, a letter is sent to the attending physician requesting him to report the case if he has determined that the patient has syphilis. On receipt of this report, antisyphilitic drugs are sent to the physician together with the pamphlet 'Syphilis in Mother and Child,' published by the United States Public Health Service."

The diagnostic value of the tuberculin test is inversely proportional to the frequency of tuberculosis infection in the community from which the patient comes. In recent decades the incidence of positive tuberculin tests in many sections has declined to such a marked degree that the tuberculin test is assuming a position of steadily increasing importance among the diagnostic procedures that may be used to aid in the identification of obscure lesions, either within the thorax or elsewhere, which may bear some clinical resemblance to tuberculosis. For many years pediatricians have employed the tuberculin test much more frequently than have physicians who treat adult patients. This has been due in part to the fact that positive tuberculin tests are much less common among children than among adults. Now that the incidence of positive tuberculin reactions has declined among adults, the tuberculin test will surely be used with steadily increasing frequency in time to come. H. Corwin Hinshaw, M.D., Mayo Clinic, Rochester, Minn.

Physical Medicine Abstracts

John S. Coulter, M.D.

EARLY TREATMENT OF BELL'S PALSY

H. P. Pickerill, C.B.E., M.S., F.R.A.C.S. and
C. M. Pickerill, M.B., Ch.B.
(From the Plastic Surgery Department,
Wellington Hospital, New Zealand)
In BRITISH MEDICAL JOURNAL, No. 4422, 458
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It is said that 75% of cases of Bell's palsy recover spontaneously, and therein we think lies the cause of lifelong disfigurement for many people. It seems to be always hoped, sometimes presumed, that the particular case in hand is or will be one of the 75, in spite of the fact that there is often no means of knowing if it will turn out to be so. We should regard Bell's palsy rather from the point of view of those who do not recover spontaneously, and say that in 25% of cases the present usual line of treatment results in complete failure and the patient is permanently disfigured; this is a more arresting point of view, and is likely to result in a considerable diminution of such failures. In every fresh case of Bell's palsy we suggest that it should be assumed not that it will probably get well if little or nothing is done, but that it is possibly one of the 25 which will not recover by itself, and measures should be taken accordingly.

Probably the chief factor in non-recovery of what should be the temporarily paralyzed muscles is their immediate and continued overstretching by the non-paralyzed muscles of the opposite side of the face. A common method of attempting to overcome this is by the use of a hook in the corner of the mouth attached by a loop to the ear; but, as will be shown, this is often worse than useless. A more simple and effective method of restraining the overaction of the muscles of the sound side is by means of strapping. It is applied thus.

THE STRAPPING METHOD

The lower half of the paralyzed side is first smeared thinly with vaseline or oil. Two strips of half- or three-quarter-inch strapping are then applied to the clean sound side on a level with the upper and lower lips, starting about three-quarters of an inch in front of the ear. The sound side is pushed across to the paralyzed side, and while in this position the other ends of the strapping are firmly stuck down to the mastoid process on the paralyzed side. Good and very adhesive rigid strapping must be used — not elastoplast. The strapping, once on, must be left indefinitely on the sound side. If it is removed the skin becomes sore and there is difficulty in reapplying it firmly; moreover, the patient is discouraged from persisting with the treatment. When it gets soiled another piece may be placed on top of it, and only in some real necessity should it be removed, gently, by the surgeon or nurse, with the aid of a solvent, and reapplied immediately. Non-adhesion to the paralyzed side is necessary in order to avoid the possibility of a pull on the paralyzed muscles and so that gentle massage may be given; also so that the patient may endeavour to make voluntary movements of the affected side in front of a mirror at the end of a week or ten days. The latter method is probably the most effective that can be employed to aid recovery, but it must be done while the normal side is out of action. That is to say, conditions must be such that the only thing the paralyzed orbicularis oris or zygomatic muscles have to do is to respond, even if ever so feebly, to the will to contract;

they must not be concerned also with opposing the pull of the muscles of the opposite side. The probable reason why massage and exercises are so often ineffective is that in the early stage of recovery the muscles are overpowered with work by having two jobs to do at once and again becoming overstretched, anything gained is soon lost.

Electrical Measures. — During the third week, if recovery is not obvious, the muscles may with advantage be stimulated with weak faradic currents. Minimal doses only should be used — just sufficient to cause visible contractions in the orbicularis and zygomatic muscles. The aim should be just to maintain tone and not to tire the muscle with violent contractions. A current which causes any painful sensation is much too strong, and will do harm. The current should be tried first on the operator himself and then on the sound side of the patient before being applied to the paralyzed muscles. If a current which causes contraction on the patient's sound side causes no contraction on the paralyzed side, no attempt should be made to produce contraction by using a stronger current. Short daily treatments with very weak current should be ordered. The strapping should be kept on and the above treatment continued indefinitely. It may be for only a week or two, but it may be for two or three months. The patient must be handled very strictly, and be impressed with the serious risk of taking the strapping off even for one occasion, no matter how seemingly important it may be.

SPRAINED ANKLES

A new form of treatment

Walter Scott, Lieutenant Commander (MC) U.S.N.R.

In NAVAL MEDICAL BULLETIN, 45;4;684
October, 1945

Our concepts in the treatment of ankle sprains have become modified in the past several years in at least one respect; it is now generally held that the early institution of weight-bearing serves to cut down materially the period of disability.

With these points in mind, the author sought to devise a routine which would embrace the two essential principles, namely, early weight-bearing and good ankle support, and it is the purpose of this article to describe this routine and to set forth a few suggestions which will be helpful in differentiating a fracture from a sprain.

The support principle is a simple one, based on the fact that a military boot is a good splint in itself. By the addition of felt pads to the inside, its supporting qualities are multiplied many times. After the pads are properly applied, the boot is laced tightly to the top eyelet and the patient is instructed to walk a distance of 500 yards and to return for any adjustments that may be required.

It is surprising and gratifying to see many of them return from their trial walk without the slightest limp. The bulk of these patients are sent to light duty for 48 hours, instructed to wear the pads for at least 21 days, and to return only if they have further trouble. It has been noted that about 20 per cent are likely to return, and in that group we usually find that the boots have not been laced tightly enough. A smaller percentage may require further individual care, but on the whole we are able to return our men to duty immediately with a minimum effort on the part of the Medical Corps, with a maximum of comfort to the injured man, and with an increased assurance that the ankle will be fully protected against other injuries during the healing phase.

The support should be used for at least three weeks in order to insure the best healing.

INFLUENCE OF GALVANIC STIMULATION ON MUSCLE ATROPHY RESULTING FROM DENERVATION

E. C. S. Jackson, Flight Lieutenant, R.A.F.V.R. and H. J. Seddon, Nuffield Department of Orthopaedic Surgery, Oxford

In BRITISH MEDICAL JOURNAL, No. 4423, 486
October 13, 1945

For many years the role of electrical stimulation in the treatment of lower motor neuron lesions has been the subject of lively controversy; and since the beginning of the war interest in this form of treatment has been quickened by the occurrence of thousands of cases of peripheral nerve injury. The results of animal experiments and of observations in man, though at times conflicting, are now consistent enough to warrant the formulation of certain conclusions.

It has been proved experimentally that the wasting of denervated muscle — a process

prejudicial to recovery — can be prevented to a considerable extent by regular electrical stimulation of the muscle with stimuli of long duration, such as are provided by a galvanic battery.

A fluid-displacement method was used to measure the volumetric changes in the hand in cases of ulnar paralysis, some treated with, others without, galvanism. It was found that the application of 90 stimuli daily for six days a week was almost wholly effective in preventing wasting except during the weeks immediately following denervation, though even during this period such treatment reduced the rate of wasting. The stimuli were strong enough to produce a brisk contraction, and were given at the rate of 30 a minute, with an interval of one minute between each group of stimuli to permit recovery from any possible fatigue.

There was no evidence that electrical stimulation increased muscle volume, and hence it is important to start treatment as soon as possible, since whatever has been lost through delay cannot be regained.

There is no doubt that in ulnar paralysis daily galvanic stimulation is well worth while, and that the treatment should be continued until voluntary power returns. It is not yet known whether galvanism is equally effective in preventing wasting in large masses of muscle, since a tolerable stimulus does not affect all parts of a large muscle mass equally, the deep fibres tending to escape altogether.

CONTROL OF AIR BORNE INFECTION

In THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 129;8;553 October 20, 1945

The bacteriologic studies carried out by Deryl Hart and his co-workers established that air is an important source of contamination in every operative wound. They also demonstrated that sterilization of the air in the operating room can be accomplished by ultraviolet irradiation. Robertson and her associates obtained a striking reduction in cross infection in infant wards by ultraviolet irradiation. Wheeler and his associates describe a carefully controlled clinical study of the effect of the ultraviolet light control of air borne infections in a naval training center. Ultraviolet irradiation of the floors and upper air of barracks housing naval recruits was accompanied by a 25 per cent reduction of respiratory illness in those barracks equipped with high intensity sources as compared with illness in the adjacent control barracks. This fact was most noticeable in the early winter months, when illness rates were at a general high level throughout the camp. At this time the reduction of incidence in barracks irradiated with high intensity sources as compared to the controls was approximately 35 per cent.

REACTION OF DEGENERATION IN ELECTRODIAGNOSIS OF EXPERIMENTAL PERIPHERAL NERVE LESIONS

L. J. Pollock, J. G. Goldseth, A. J. Arieff, I. C. Sherman, M. A. Schiller and E. L. Tigay — p. 275 In War Medicine, Chicago, 7;275-340 (May) 1945 Abstracted in THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 128;15;1129 August 11, 1945

Pollock and his associates describe the data obtained from the examination of denervated and recovering muscles in cats as related to the characteristics of the reaction of degeneration; they compare such data with some obtained in human subjects and discuss the usefulness of the reaction of degeneration as a diagnostic and prognostic sign. For the most part Erb's description of the characteristics of complete reaction of degeneration have been confirmed by their studies. They emphasize that faradic stimulation is effective throughout degeneration, denervation and regeneration, provided sufficient amperage is employed. The changes of response to galvanic stimulation of "infinite time" which characterize complete reaction of degeneration are (1) hyperirritability of muscle to galvanic stimuli, (2) sluggishness of relaxation of the contraction wave, (3) lessening of the ratio between amperage necessary to produce tetanus and rheobase to almost unity and (4) increase of efficacy of the anodal closing stimulus to equality with the cathodal closing stimulus. Unequivocal signs of recovery are (1) a sudden increase in rheobase, (2) an increase of ratio between the amperage necessary to produce tetanus and rheobase and (3) an increase in efficacy of the cathodal closing stimulus as compared with the anodal closing stimulus. The electrical sign of recovery characterized by the sudden increase of rheobase ante-

dates the recovery of motion and sensation for long periods, in many by many weeks. The other signs likewise antedate other clinical signs of recovery. Electrotherapy has no effect on the response of muscles to electrical stimuli.

TOURNIQUET PARALYSIS

Analysis of three cases of surgically proved peripheral nerve damage following use of rubber tourniquet

Major I. Joshua Speigel and
Lieutenant Colonel Philip Lewin, Medical Corps, Army of the U. S.

In THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 129;6;435
October 6, 1945

Severe damage of peripheral nerves can occur as a result of application of a rubber tourniquet for surgical ischemia.

Factors involved in the production of the paralysis are (a) pressure necrosis at the site of tourniquet application, with fibrosis and production of neuromas, (b) ischemia below the site of application of the tourniquet with death of the ischemic portion of the nerve, fibrosis and production of a neuroma in continuity, and (c) a combination of the foregoing two situations.

The radial and sciatic nerves are the most vulnerable to tourniquet paralysis.

Every case of tourniquet paralysis of a peripheral nerve immediately on its discovery should receive intensive physical therapy over a period of eight to twelve weeks. If, at the end of this time, no appreciable return of function is evident, surgical exploration of the involved nerve should be performed and a neurolysis or even neurorrhapy (if feasible) should be attempted.

The Campbell-Boyd pneumatic constrictor appears to be the most efficient and least harmful of the constrictors.

BED-REST IN TUBERCULOSIS

Its Dangers and Proprieties

William M. Peck and Henry Stuart Willis

In THE AMERICAN REVIEW OF TUBERCULOSIS, 52;1;20
July, 1945

1. Pulmonary infarction and embolism of the pulmonary artery were found in 1.5 per cent of 751 autopsies on tuberculous persons.

2. Certain other dangers may be associated with bed-rest in this disease. Among these are the failure:

a. To obtain adequate pulmonary drainage.

b. To meet the emotional maladjustment so often present in patients.

c. To correlate properly collapse therapy and a bed-rest regimen.

3. The evils which adhere to bed-rest are incident to its mode of application. Good bed-rest will avoid these dangers and retain its full therapeutic value. Poor bed-rest is often therapeutically inert and can be aptly called bed-fatigue.

4. Proper bed-rest should include mental repose, muscular relaxation and adequate pulmonary drainage and should not be thought of as mere regimentation in recumbency.

5. Bed-rest is inherently valuable but unreliable when administered indifferently. It warrants constant, critical attention by the physician in order to insure good results.

RECENT FRACTURES OF THE CARPAL SCAPHOID

Lieutenant Colonel Ralph Soto-Hall
Medical Corps, Army of the United States

In THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 129;5;337
September 29, 1945

Early and rapid healing will take place in fractures of the tubercle of the scaphoid. In this infrequent extra-articular fracture, position of the wrist is not of consequence. On the other hand, fracture through the waist is the most common, and in this type correct and adequate immobilization is very important. Immobilization should be complete and undisturbed for at least nine to ten weeks; a large percentage of fractures will heal in this time, but four to five weeks longer may be necessary.

To diagnose the greatest possible percentage of unsuspected cases of tuberculosis, to place these people under immediate and adequate care, to render them and the community safe from further spread of their disease, to rehabilitate every patient into a productive member of society — these are our tasks. Diagnostic procedures that guarantee the maximum return in case finding are those that safely apply the clinical lessons of the past to the pressing problems of the present. No thorough clinician relies exclusively upon a solitary diagnostic aid, even when circumstances strongly tempt him to do so. Ed., Tuberculosis Abstracts, National Tuberculosis Assn.

Industrial Health

Committee On Industrial Health — Jos. H. Chivers, Chm., 836 S. Michigan Ave., Chicago 5, Frank P. Hammond, H. A. Vonachen, R. I. Barickman, C. O. Sappington, Milton H. Kronenberg.

Effective medical service in industry must have the understanding and co-operation of management. The following article from Industrial Medicine (October 1945) shows a practical method of service inventory in an industrial medical program.

HOW THE EMPLOYER MAY EVALUATE HIS MEDICAL SERVICE

F. M. R. Bulmer, M.B., B.Sc.,
and
G. R. McCall, M.D., D.P.H.,
Department of Medical Services,
Allied War Supplies Corporation,
MONTREAL

It may be presumptuous to suggest the means by which an employer can evaluate his medical service. Our experience in large and small war plants, however, indicates that management is anxious to have a yardstick by which it can measure the effectiveness of its medical service. This applies particularly to those who are genuinely interested in the welfare of their workers. Frequently employers state that they are in a position to evaluate the work of their entire organization with the exception of that of the medical department. They do not expect a direct profit from this department but they feel that some system of accounting should be provided which will show whether the activities are commensurate with the money expended. Other services are provided by industry but the benefits realized are not always sufficiently tangible to permit a profit and loss sheet. Their work is, however, usually reported in such a manner that its value can be readily appreciated.

The more progressive employers are rapidly realizing that their medical departments should be used for the early detection of non-occupational illnesses, as well as for pre-placement examinations and the care of emergency occupational conditions. They realize also that the early detection of illness can be accomplished only if the workers contact the medical department when they are in the initial stages of ill health. Such contact can be effected by voluntary visits or through a system of periodic examinations. If periodic examinations only are used, the early detection of serious ailments will often be missed. It is important that the workers have ready access to the medical department for the diagnosis of trifling conditions which may be the initial stages of more serious trouble. It is not advisable to depend entirely on periodic checks conducted every year or at longer intervals, for the early detection of disease. On the other hand it is neither practical nor desirable to examine large groups of workers routinely at shorter intervals. The apprehension which minor symptoms may induce is generally recognized, as is also the reluctance to do something definite about them until pain or disability forces an issue. We feel that, where a proper relationship exists between the medical department and the rest of the plant, most workers will seek early medical advice, even for apparently negligible symptoms.

It is natural that an employer should be interested in the pre-placement examination. This subject has been greatly stimulated by army experience. It should be realized, however, that army experience is not necessarily applicable to industry. Warfare requires personnel who can meet conditions of maximum physical output for a continued period of time. On the other hand,

in industry the physical output is more moderate and maximum bursts are seldom required. Industry to a great extent uses machinery for heavy work. Many industrial jobs do not require an undue amount of physical energy; in fact many workers suffer more wear and tear getting to and from work than in the actual performance of their jobs.

In examining applicants for employment the general rate of rejection on medical grounds should be low. Certain categories of workers should not be placed at jobs where their failure could endanger others or which could present definite risks to themselves. Emotional maladjustment of workers in industry cannot always be predicted by the pre-placement examination. It should be realized however, when placing an individual worker, that his probable reactions to the foreman, to the surrounding workers, and to his environment are to be considered, as well as the physical demands of the particular job.

In accordance with the ethics of his profession the industrial physician must treat individual health records of workers in a confidential manner. Unfortunately, however, an atmosphere of secrecy sometimes pervades all the work of the medical department at the expense of proper cooperation with other departments, even with management.

When it functions properly the medical department is an integral part of the whole organization and it should follow a definite procedure worked out in cooperation with all other departments. The use of a questionnaire is of value to ascertain the efficiency of arrangements between all departments, as regards health and safety. The need of such a questionnaire was indicated during our surveys of certain industries in Canada. A detailed inquiry form used during these surveys was completed from information supplied by the heads of the various departments. Frequently it was found that different departments, especially medical, safety, and personnel, had developed independent programs without sufficient collaboration or understanding of the common problems and accepted methods of procedure. Such a situation leads to confusion and sometimes to friction and to duplication of effort. It is recognized that each industry has its own peculiar problems and pattern of organization, but there is no reason why a master service program, formulated by management in conjunction with the various departments of the organization, cannot be developed.

The questionnaire used to test the relationship of the medical department to other departments should be filled out by the heads of the departments concerned. The following questions are suggested:

1. What procedure is followed to permit a worker to visit the medical department?
 - (A) For major accidents.
 - (B) For minor accidents.
 - (C) For major illness.
 - (D) For minor illness.
 - (E) For health advice.

2. Who decides when a sick or injured worker can return to work?
 - (A) Following occupational injury or sickness.
 - (B) Following non-occupational injury or sickness.

3. What disposition is made of workers in relation to their medical category? Who decides their final placement?

4. In placing workers, where is the distinction drawn between "light" and "heavy" work?

5. What "toxic" materials are used?
 - (A) From what source do you obtain information as to the toxicity of these materials?
 - (B) What other departments know the nature of these materials?
 - (C) What methods are used to protect workers handling "toxic" materials?

6. What fire or explosion hazards are present?
 - (A) From what source do you obtain information as to the degree of fire or explosion hazard?
 - (B) What other departments know the nature of these hazards?
 - (C) What measures are used to protect workers from inflammable materials or from explosions?

7. What action do you take in connection with complaints respecting hazardous or unhealthy working conditions? What other departments are notified of such complaints?

8. What action do you take when a new

process or new materials are used involving possible hazards?

9. What arrangements have been made in the event of a major catastrophe?

10. Do you attend plant meetings respecting safety, health and other welfare work? What other departments attend such meetings?

11. Are first aid courses provided?
 (A) Who does the teaching?
 (B) How many workers attend?

12. Do you make inspections for cleanliness, maintenance of sanitary facilities and cafeteria service?
 (A) Who else inspects your section for the above conditions?
 (B) If conditions are not satisfactory, to whom do you report?

13. Who makes and enforces safety rules?

After a questionnaire of this type has been answered and the results studied, it will soon be realized whether or not there is inter-departmental cooperation in that particular plant. The next step is to find out how much is being spent by the medical department and what service value is being received. For years it has been a common practice to quote industrial medical costs in terms of so much per worker per year. The figures given vary considerably. This variation is due largely to the type of service provided and/or to the salaries paid to the staff of the medical department, which, in turn, vary according to the nature and location of the plant.

In order to clarify the picture it is necessary to outline the program of a minimum industrial medical service. Our opinion is that each worker should be medically examined at the time of employment and should be checked at regular intervals. The interval will depend on his age, his physical condition at the time of employment, and whether he is in contact with toxic materials. Facilities should be provided for the emergency care of occupational conditions and of ordinary illnesses occurring during working hours. Initial medical treatmnet for non-occupational ailments should be supplied and advice given on health problems. The medical department should show leadership in the matter of sanitation and environmental conditions in the plant. This requires a program of plant inspection. It is also important that the medical department cooperate with other departments in the development and enforcement of programs designed for the welfare, safety and rehabilitation of workers and for the betterment of working conditions.

Our experience has shown that where this type of medical service is provided for a working population of men and women in roughly equal numbers, approximately 12 visits per worker per year are made to the medical department. Where women alone are employed the figure is higher (about 18 visits); where men alone are employed it is less (about 10 visits per worker per year). At least one-half of the visits are for minor sickness. About 60% of the accident visits and 80% of the sickness visits are initial visits, while the balance are repeat visits for the same conditions.

Our investigations would suggest that wherever the visit rate drops below eight per worker per year, in a mixed working population, the medical service needs a check-up. A low-visit rate indicates two possibilities: (1) the workers are not being permitted reasonable access to the medical department; (2) the service provided is not satisfactory. In the latter case it has been found frequently that the work of the medical department is confined to company responsibilities with no service for minor conditions of ill-health, and no attempt is made to conduct an adult health program. Such a restricted service is frequently welcomed by the company physician. It reduces considerably the number of visits to his department.

An extremely high visit rate, e.g., over 18 visits per worker per year in a mixed working population, would suggest two possible conditions, both usually the responsibility of management: (1) there is no satisfactory procedure whereby employees can contact the medical department, the workers coming and going as they please; (2) there are in the plant certain environmental conditions which cause an increase in the number of minor accidents or in the incidence of ill-health.

The employer is in a position to obtain the total yearly cost of his medical department. A breakdown of this information will reveal that considerably over one-half of the money spent is for salaries or wages of personnel. Our experience indicates that about 70% of the total operating cost is for this purpose. We suggest that

some "work unit" should be used, in addition to the cost per worker per year, when evaluating a medical service. We consider that the "visit" to the medical department is a satisfactory work unit, and that the "cost per visit" as well as the "cost per worker per year" should be given in reports on the work of the medical service.

An employer establishing a medical service can estimate the cost on the basis of so much per worker per year. This cost will vary, depending on the salaries currently paid in the locality for medical department personnel. Frequently other companies in the same area operating a medical service will divulge the amount spent per worker per year. After the estimated cost per worker per year has been agreed upon, this amount divided by 12 (the anticipated number of visits per worker per year) will give the probable "cost per visit."

At the end of the year, if the actual visit cost is much lower or higher than the estimated cost, the service needs investigation along the lines previously mentioned. Our experience in medium and large war plants provided with a 24-hour service would indicate that the cost per visit to the medical department is approximately one dollar. Under peace conditions of operation on an eight-hour day and based on current salary rates, the cost per visit would be somewhat lower than this figure.

SUMMARY

An attempt has been made to provide the employer with a clearer concept of the functions of an industrial medical service.

A method has been outlined to determine whether the medical service is properly integrated in the plant organization.

A system has been described to evaluate the work done in a medical department using the visit rate and the cost per visit as well as the cost per worker per year.

SIMPLE, RAPID METHOD FOUND TO DETECT SICKLE CELL ANEMIA

Sickle cell anemia, as great a masquerader as syphilis, predominantly a disease of Negroes, can be detected simply, rapidly and accurately by new tests devised by two New Orleans physicians. They call the method the "diagnostic parameter."

Travis Winsor, M.D., and George E. Burch, M.D., New Orleans, describe in *The Journal of the American Medical Association* of November 17 the two tests by which they discovered 27 cases of sickle cell anemia, a peculiar red cell deformity, among 612 consecutive Negro patients tested routinely for the last two years on admittance to Charity Hospital for treatment. The two methods, the aeration-tourniquet test and the oxygen-carbon dioxide test, both help to measure the sedimentation rate of the blood. If the difference in the sedimentation rates between the treated and untreated blood, which is an important process in the tests, is greater than 20 millimeters in the first test and 27 millimeters per hour in the second method, then the chances are 98 in 100 that the patient has sickle cell anemia.

The authors say that since "sickle cell anemia is such a great imitator and because it may remain so subtle, it is necessary. . . .as in syphilis, to study the blood routinely for sickle cell anemia in all Negro patients."

Usually, the doctors warn, this disease masquerades for such diseases as rheumatic fever, tuberculosis, Hodgkin's disease and acute surgical diseases of the abdomen. Because surgical procedures are dangerous in patients suffering with this disease and there is necessity for quick and accurate diagnosis, the authors recommend this "diagnostic parameter" method as highly reliable.

The disease is marked by chronic anemia, a quantitative or qualtative deficiency in the blood, of unknown cause, which is confined almost entirely to the Negro race, is hereditary and is characterized by the red blood cells of the patient acquiring a sickle-like shape. Patients with this disease frequently have chronic ulcers of the legs and pains in the joints. There is usually abdominal pain and fever is common from time to time.

The authors concluded that "the change in hematocrit reading following the treatment of sickle cell anemic blood with carbon dioxide is of diagnostic value. In no instance did the diagnostic parameter give a false response. This is particularly important in view of the fact that it is a rapid procedure and therefore of great value in the management of acute medical and surgical problems among Negro patients."

There is no effective treatment of the disease except blood transfusion in the anemic stages, and, if possible, correction of the anemia.

News of the State

PERSONALS · COMING EVENTS · MARRIAGES · DEATHS

BOONE COUNTY

Capt. Earl S. Davis of Belvidere, after three years in service has been released and has resumed his practice in Belvidere.

BUREAU COUNTY

Capt. George Meagher of DePue, who has served in the army medical corps since December, 1941, has been released from duty and has indicated he will become associated with Dr. L. M. Dunn of DePue.

Major H. J. Jacobs, Spring Valley, has been discharged from the medical corps and plans to re-open his office in Spring Valley.

CHAMPAIGN COUNTY

Doctor Donald L. Glenn of Berwick, Pa., has been added to the staff of the Carle Memorial Hospital, Urbana. He began his work there November 5 as the general diagnostician in internal medicine.

Major J. B. Gillespie has been released from the army and expects to return to his work on the staff of the Carle Memorial Hospital in the near future.

COLES COUNTY

The following officers have been elected to serve for the coming year in the Coles County Tuberculosis Association: President, Dr. C. E. Morgan, Mattoon; Dr. N. C. Iknayan re-elected treasurer; Mrs. J. T. Roy, vice president; Mrs. Lawrence Daily, secretary; and Mrs. Mildred Fish, seal sale chairman.

COOK COUNTY

Mr. Ray E. Brown, formerly superintendent of the North Carolina Baptist Hospital, Winston-Salem, N. C., has been appointed assistant superintendent of the University of Chicago Clinics. He will be assistant to Dr. George Otis Whitecotton, superintendent.

Dr. Dudley B. Reed has retired at the University of Chicago School of Medicine with the title of professor emeritus of hygiene, department of medicine. Dr. Reed, who is health director of the university's health service, retires under the age limit after thirty-four years service.

A course in electrocardiographic interpretation for graduate physicians will be given at Michael Reese Hospital by Dr. Louis N. Katz, Chicago, director of cardiovascular research. The class will meet each week starting Wednesday, February 13, for twelve weeks, from 7 to 9 p.m. Further information and a copy of the program may be obtained on application to the Cardiovascular Department, Michael Reese Hospital.

A permanent endowment fund has been set up at the University of Chicago School of Medicine in the name of the class of 1944. The fund resulted from the proceeds from the sale of the first yearbook of the medical school, which was the activity of the class of 1944. According to the Medical Alumni Bulletin this establishes a precedent which, it is hoped, will inspire other classes to aid in placing the Medical Alumni Association on a permanently secure financial basis.

The Third Annual D. J. Davis Lecture on Medical History was held on November 21st at the University of Illinois College of Medicine. Dr. Carl E. Black, Jacksonville, Illinois, spoke on "Medical Practice Before the Hard Roads."

Dr. J. B. Deutsch, after serving three years in the U. S. Army Medical corps has returned to civilian practice and reopened his office in Chicago.

Dr. Casper M. Epsteen, retired from the Army has returned to practice in Chicago.

The North Side Branch of the Chicago Medical Society held a regular meeting, Thursday, December 6 at the Drake Hotel. The speaker, Captain Edward L. Bortz (MC), USNR will discuss "Implications of the Atomic Bomb."

Dr. L. D. Reid, assistant superintendent of the Presbyterian Hospital since July, 1944, has been named superintendent to succeed Herman Hensel, whose resignation because of ill health was accepted by the hospital.

The American Hospital association announced the appointment of Edgar Blake Jr., superintendent of Wesley Memorial hospital, as member of the association's council on education. At the same time, Dr. M. T. MacEachern, associate director of the American College of Surgeons, was reappointed chairman of the hospital association's council of international relations.

The Thirtieth Annual Meeting of the Institute of Medicine of Chicago was held December 4 at the Palmer House. Dr. Wm. C. Danforth, Professor of Obstetrics and Gynecology, Northwestern University Medical School, discussed "The Beginnings of Asepsis: The Story of a Tragic Life".

Col. Paul L. Schroeder, psychiatrist of Oak Park, Illinois, on leave from the University of Illinois and St. Joseph's hospital, Chicago, has reported for duty to Justice R. H. Jackson, chief prosecutor of high nazi officials. Col. Schroeder will aid in diagnosis of Rudolph Hess case.

Col. Samuel Hoffman, who served three and a half years in the army medical corps, has been elected a director of the Hektoen Institute of Medical Research. The institute is affiliated with County hospital, with which Col. Hoffman was associated before joining the army. He also is an assistant professor of pediatrics in the University of Illinois medical college.

A Bronze Star medal has been awarded to Dr. Richard G. Fort, Evanston, for his work from July 14, to August 25, 1944. According to a citation accompanying the award "Capt. Fort enabled his medical battalion to provide efficient medical service for the sick and wounded of the division, maintaining superior liaison of widely separated subordinate units.

"Capt. Fort often traveled far in advance of the medical battalion to reconnoiter sites for installations necessitating long rides day and night under trying conditions. His profound knowledge of medical battalion functions, and his efficient performance of duties reflect great credit upon himself and on the medical corps." Dr. Fort served four years overseas.

Capt. Walter V. Norak, Maywood, has returned to private practice after serving three years in the Medical corps of the U. S. Army.

DE KALB COUNTY

Maj. John W. Ovitz, Jr., Sycamore, has returned to this country after four years and 10 months in service and 22 months overseas.

Dr. Grant Suttie announced the re-opening of his office in DeKalb.

DE WITT COUNTY

Capt. Wiley R. Marvel, former Weldon physician, arrived in New York after two years service overseas in India and in Burma. He will receive a 60 day terminal leave and be released from active duty by Jan. 1.

Commander Owen W. E. Nowlin, USNR, has returned to Farmer City after three years in service. At the conclusion of his terminal leave, December 27, he expects to resume his practice with his brother, Dr. Wilfred Nowlin in the Nowlin Clinic.

DOUGLAS COUNTY

Dr. Carleton Smith, Villa Grove, has opened an office in Peoria where he will practice.

DU PAGE COUNTY

Dr. John H. Raach, Jr., will reopen the office of his late father, Dr. John H. Raach, Sr., in Wheaton.

The regular meeting of the DuPage County Medical Society was held on November 28th at the Elmhurst Community Hospital. A technicolor film was shown on "Managing Fresh Wounds of Violence" and Doctor Edith Potter, University of Chicago-Lying-In Hospital discussed "The RH Factor in Relation to Pregnancy".

FAYETTE COUNTY

Commander Miller Greer, USNR, has been released from active duty and will resume the practice of medicine with his brother, Dr. Mark Greer in Vandalia.

Dr. I. O. Adams has opened an office in Farina where he will practice medicine.

FORD COUNTY

Capt. R. L. Kenward has been released from the army and has resumed his practice as physician and surgeon in Melvin.

FRANKLIN COUNTY

Dr. John W. Monroe, Benton, has been released from the U. S. Army Medical Corps and has re-opened his office.

HENRY COUNTY

The army has announced the promotion from Captain to Major of A. W. Wellstein, Geneseo.

KANKAKEE COUNTY

The Kankakee City Medical Society gave a dinner November 15th in honor of the physicians who have returned from the Armed Forces.

LA SALLE COUNTY

The regular monthly meeting of the La Salle County Medical Society was held November 8th at the Hotel Kaskaskia, La Salle. The speaker of the evening was Dr. Philip Thorek, Chicago, who talked on "Acute Abdominal Emergencies."

Major E. H. Rayson, Earlville, has been discharged from the medical corps and will re-open his office. He recently returned from service at various stations in India.

LAWRENCE COUNTY

At a recent meeting of the Lawrence County Medical Society, Dr. E. M. Cooley, 75, of Lawrenceville was admitted to the Fifty Year Club of the Illinois State Medical Society.

LIVINGSTON COUNTY

Capt. E. F. Joss of Dwight has returned from 25 months of service in the European theater of operations and expects to resume his private practice in Dwight shortly.

MACOUPIN COUNTY

The Macoupin County Medical Society held a meeting on November 27th at which time Dr. Harry Mantz of Alton discussed the subject: "Differential Diagnosis of Chest Pain."

MADISON COUNTY

Dr. Harry Mantz discussed "Heart Disease" at the November 15th meeting of the Alton Exchange Club at Mineral Springs Hotel.

Capt. R. G. Mindrup of Jerseyville has returned to the States after spending 17 months with the Medical Corps in Europe.

At the regular meeting of the Madison County Medical Society, Dr. E. W. Cannady of East St. Louis spoke on "Diseases of the Stomach and Duodenum."

MC DONOUGH COUNTY

The McDonough County Medical Society cooperated with the Division of Service for Crippled Children of the University of Illinois in arranging a clinic November 6th for handicapped children.

PEORIA COUNTY

Robert D. Coghill, Ph.D., Peoria, has been appointed associate research director of Abbott Laboratories effective November 1. Since 1939 he has been chief of the Fermentation Division, Northern Regional Research Laboratory, U. S. Department of Agriculture, in Peoria.

The Peoria Medical Society held a meeting November 20 with Dr. David Slight speaking on "Psychiatry and General Medicine".

PERRY COUNTY

Dr. J. W. Stevens has been discharged from the U. S. Navy after more than three years of service, and will resume practice in DuQuoin.

Dr. G. H. Edwards of Pinckneyville has resumed the practice of medicine in Pinckneyville after his recent discharge from the army.

Dr. B. I. Hall recently discharged from the army where he served in the Medical Corps while attached to an Airborne Division has resumed the practice of medicine in DuQuoin.

PIATT COUNTY

Major George A. Sexton expects to return to Monticello to resume practice as soon as his terminal leave expires and he will revert to inactive status in the army reserve.

Capt. E. W. Weir, Atwood, expects to resume practice about the first of the year. He expects to receive a discharge from the army medical corps soon, having served since July 1942.

PIKE COUNTY

A clinic for physically handicapped children was held at the Illini Community Hospital in Pittsfield on November 2. The Clinic was conducted by the University of Illinois Division of Services for Crippled Children in conjunction with the Pike County Medical Society.

ROCK ISLAND COUNTY

Dr. E. L. DeGowin was the guest speaker at the November 13th meeting of the Rock Island County Medical Society. Dr. DeGowin talked on "Treatment of Thyrotoxicosis by Thiouracil."

ST. CLAIR COUNTY

The St. Clair Medical Society broke rigid rules of ethics of long standing by inserting advertisements paid for by the society announc-

ing the return of four local doctors to their former practice after service in the armed forces.

The advertisements announced the return of Dr. Owen J. Eisele, Dr. John F. Brennan, Dr. Olin B. Boyd, and Dr. Ralph Knewitz and each advertisement carried a picture of the doctor, the date and place of the opening of his office, and the statement: "It is the earnest wish of his colleagues of this society, that all his former patients should return to him."

This is being done, according to the St. Clair Medical Society in an endeavor to assist the doctor returning from service to resume his practice in the shortest possible time, and to provide a way for his patients to learn of his return.

Dr. Bert Moore has succeeded Dr. Robinson Bosworth as St. Clair county tuberculosis specialist and director of Pleasant View sanatorium at Fairview. Dr. Moore comes to St. Clair county from the U. S. Army. For four years he was chief of the respiratory section of the Camp Davis Station hospital, Camp Davis, N. C., near Wilmington, N. C. For nine months he was chief medical officer of the Field Artillery Replacement and Training center at Fort Bragg, N. C. and for the past five months he was attending surgeon at Fort Bragg.

Dr. H. P. Dexheimer former physician of O'Fallon has been granted a terminal discharge from the Army Air Corps and is planning to resume his practice shortly.

SANGAMON COUNTY

Dr. Rex S. Campbell of Springfield has returned home following his separation from the army and will resume his practice in Springfield as surgeon and physician.

WARREN COUNTY

Dr. Russell Jensen, Monmouth, has returned from military service and is practicing medicine in Monmouth.

WHITESIDE COUNTY

The Whiteside County Medical Society elected the following officers for the coming year: President, Dr. Dale Scott; vice president; Dr. Neal Marquis; secretary-treasurer, Dr. G. J. Pohly; delegate to annual convention, Dr. L. S. Reavley; legislative chairman, Dr. H. L. Pettitt; board of censors, Dr. G. J. Pohly, Dr. H. L. Pettitt and Dr. J. L. Snavely.

WILL COUNTY

Capt. Charles Brobst will resume the practice of medicine in Aurora soon.

WINNEBAGO COUNTY

Major Alexander Braze, now with the 61st Portable Surgical Hospital Unit, attached to the 25th Infantry (Tropic Lightning) division on Luzon has been awarded the legion of merit medal for exceptionally meritorious service in operations against the Japanese on Luzon.

A veteran of 12 months of overseas service, Major Braze served on New Guinea before seeing action on Luzon. He is entitled to wear the American defense ribbon, the Asiatic-Pacific theatre ribbon with two campaign stars and the Philippine liberation ribbon with one star.

The Southern Illinois Medical Association at its 71st Annual meeting elected the following officers: Dr. C. D. Nobles of Anna, President; Dr. W. I. Lewis, Herrin, first vice president; Dr. Beverly Moore, Benton, second vice president and Dr. T. B. Williamson, Mount Vernon, re-elected secretary-treasurer.

MARRIAGES

John E. Miller to Miss Emma Louise Schaefer, both of Quincy in August.

DEATHS

Peter Bassoe, Chicago, University of Illinois College of Medicine, 1897. Professor of nervous and mental diseases at Rush Medical College for many years. Staff at Presbyterian Hospital. Died November 5th following two weeks illness. Age 71.

W. A. Borin, Bartonville, Chattanooga Medical College 1891. Practiced medicine in Bartonville since 1906. Died November 5th following a stroke. Age 79.

W. E. Code, Chicago, Illinois Medical College 1904. Staff physician for county welfare bureau for 25 years. Died October 29th. Age 68.

W. M. Crosier, Alexis, University of Illinois College of Medicine 1907. President of Warren County Medical Society 1941 to 1943. Had practiced in Alexis since 1907. Died October 27th. Age 69.

James I. Doyle, Rapid City, So. Dakota, Loyola University School of Medicine 1924. Practiced medicine in Chicago for a short time before moving to Rapid City, South Dakota. Died October 24th. Age 50.

Orville K. Kaylor, Granite City, Barnes Medical School 1903. Died October 24 following extended illness. Age 67.

W. A. Miles, Viola, Rush Medical School 1898. Practicing physician for 44 years at Viola. Former chairman of the Mercer County Medical Society. Died October 26th. Age 77.

E. L. Ozment, Harrisburg, St. Louis College of Physicians and Surgeons 1906. Died of a lung ailment October 29th. Age 65.

Carl R. Peterson, Chicago, retired, Jenner Medical College 1906. Had practiced medicine on the

north side of Chicago for 30 years prior to his retirement several years ago. Died November 8th. Age 69.

I. D. Rawlings, Kansas, retired, Northwestern University Medical School. Director of the Illinois State Health Department 1921 to 1929. Died October 21st. Age 76.

Burget Runnels, Milledgeville, Hahnemann Medical College 1905. Physician at Milledgeville for nearly 40 years. Died Nov. 1st. Age 68.

Benj. D. Satek, Chicago, retired. Chicago Medical School 1917. Former member of the health department. Died October 7th. Age 62.

Clarence G. Shearon, Wilmette, Northwestern University School of Medicine 1927. Associate in surgery at the Northwestern University School of Medicine, Senior surgeon at St. Luke's Hospital. Died following a heart attack November 17th. Age 46.

G. A. Sihler, Litchfield, McGill University, Montreal 1883. Had practiced medicine in Litchfield for more than 50 years. Member of Illinois State Medical Society "Fifty Year Club". Died October 24 following an extended illness. Age 84.

Ludwig S. Simon, Los Angeles, retired. College of Physicians and Surgeons, Columbia University 1894. Started to practice in Chicago in 1897 on the staff of Michael Reese Hospital until 1938. Died of chronic myocarditis on October 7th. Age 75.

Isabel M. Weaver, Kankakee, Hahnemann Medical College 1907. Staff physician at the Kankakee State hospital the past 15 years. Died November 14 after a brief illness. Age 64.

Leonard Weissman, Chicago, University of Illinois College of Medicine 1936. Formerly assistant medical superintendent of the Cook County Hospital. Killed over Germany, November 8th. Age 34.

John R. Wilkinson, Kankakee, Hahnemann Medical College 1911. Practicing physician in Kankakee for 34 years. Died November 9th. Age 68.

SERIOUS HEART INFLAMMATION TREATED SUCCESSFULLY WITH PENICILLIN

Twenty patients with subacute bacterial endocarditis, a disease involving inflammation of the lining membrane of the heart and previously considered fatal, were treated with penicillin last year at the University of Pennsylvania Hospital, with the result that 16 had definite subsidence of their infection. Of these 12 are still alive, 8 having died of other complications according to a report in the November 24 issue of *The Journal of the American Medical Association.*

Harrison F. Flippin, M.D., Robert L. Mayock, M.D., Franklin D. Murphy, M.D., and Charles C. Wolferth, M.D., with the technical assistance of Marjorie Wiley, Philadelphia, wrote that "we employed 300,000 units of penicillin a day for fourteen days as the initial course. This appeared adequate in 14 of the 20 cases. However, in view of subsequent experience with 16 additional cases of the disease, not included in this report, we believe that all patients with subacute bacterial endocarditis should receive at least 500,000 units a day for at least five weeks."

The penicillin was injected into the veins of the patients, but, according to the authors, there is no reason to believe this method is superior to injections into the muscles.

Subacute bacterial endocarditis usually attacks valves of the heart that are already damaged. The germ which is responsible for the condition in 90 to 95 per cent of cases is the Streptococcus viridans, while the gonococcus and the influenza bacillus are the causes in 5 to 10 per cent.

Since infection is so dangerous in this disease, the authors urge "as a precaution against reinfection, a careful search for possible foci of infection, such as infected teeth and tonsils, should be made."

Although only 12 patients lived, the authors wrote that "of the 8 who did not survive 4 were completely free of active infection and died as a result of heart disease. Three patients in this group failed to respond to therapy, and the eighth died soon after treatment was completed as a result of an acute pulmonary embolus."



With children . . . "... the benzedrine inhaler can be satisfactorily employed for young children for the relief of obstructive symptoms in the nasopharynx due either to infection or to allergic edema. No untoward symptoms were noted from the use of the inhaler."

Vollmer, E.S.: Use of the Benzedrine Inhaler for Children, Arch. Otolaryng. 26:91.

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a better means of nasal medication

In a recent survey of pediatricians, 77% were found to use Benzedrine Inhaler, N.N.R., in their practice.

Children accept Benzedrine Inhaler therapy willingly, and show none of the hostility which so often complicates the administration of drops, tampons, or sprays. Each Benzedrine Inhaler is packed with racemic amphetamine, S.K.F., 200 mg.; menthol, 10 mg.; and aromatics. Smith, Kline & French Laboratories, Philadelphia, Pa.

When Bacteremia Supervenes...

BEFORE the advent of penicillin, bacteremia had to be regarded as a grave prognostic sign since distant secondary foci of infection were apt to be established before the organisms could be eradicated from the circulating blood. Penicillin has improved this outlook.* Used early and in adequate dosage, it has proved successful in combating bacteremia caused by susceptible organisms. Penicillin usually produces rapid response, leading to sterilization of the blood stream and to marked improvement or complete disappearance of the infection.

*Larsen, N. P.: Observations with Penicillin, Hawaii M. J. 3:372 (July) 1944.

Stainsby, W. J.; Foss, H. L., and Drumheller, J. F.: Clinical Experiences with Penicillin, Pennsylvania M. J. 48:119 (Nov.) 1944.

Lockwood, S. J., White, W. L., and Murphy, F. D.: The Use of Penicillin in Surgical Infections, Ann. Surg. 120:311 (Sept.) 1944.

Kenney, J. F.: Report of a Case of Staphylococcus Bacteremia Treated with Sulfadiazine and Penicillin, Rhode Island M. J. 27:663 (Dec.) 1944.

PENICILLIN — C. S. C.

These features bespeak the physician's preference for Penicillin-C.S.C.: It is made under rigid laboratory controls which safeguard its potency, sterility, nontoxicity, and freedom from fever-inducing pyrogens. The high state of purification reached in Penicillin-C.S.C. makes untoward reactions comparatively rare, even when massive dosage and prolonged administration are required. Penicillin-C.S.C. is available in vials (20-cc. size) of 100,000 and 200,000 Oxford Units respectively.

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RELIEVES ITCHING PROMPTLY . . . PROTECTS . . . AIDS HEALING
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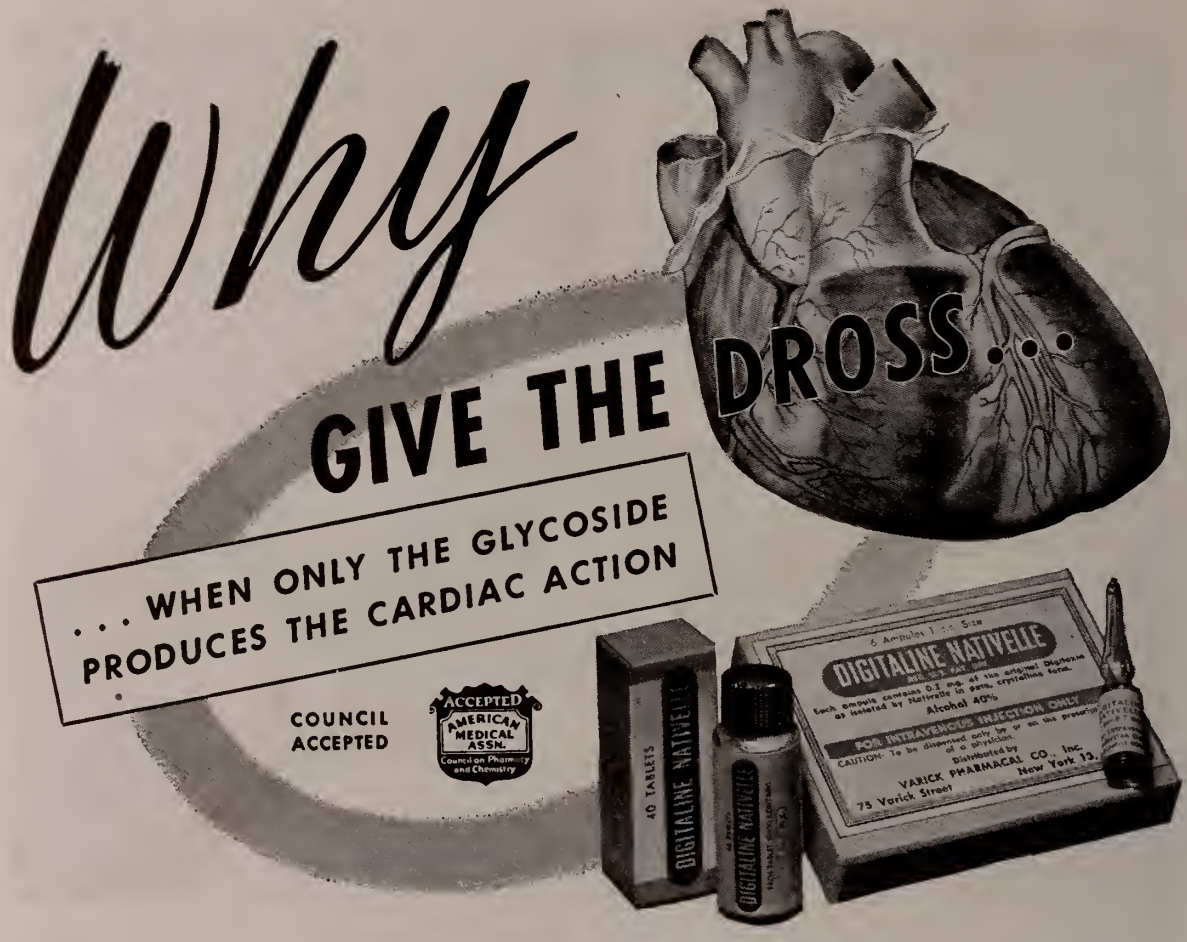
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Since it is completely absorbed on oral administration, probably directly from the stomach, it produces the same result whether given by vein or by mouth, and nausea and vomiting due to local irritation are almost never encountered.

In urgent cases—provided the patient has not received digitalis in any form for two weeks—the average dose of 1.2 mg. for initial digitalization can be given safely at one time by mouth and will produce its full therapeutic effect in 3 to 6 hours.[2] The average maintenance dose is 0.1 mg. per day, to be increased or decreased as required.

[1] N.N.R., 1941, page 210.
[2] Gold, H.; Cattell, M.; Modele, W.; Kwit, N. T.; Kramer, M. L., and Zahm, W.: J. Pharmacol. & Exper. Therap. 82:187 (Oct.) 1944.

• • •

Digitaline Nativelle is available through all pharmacies in 0.1 mg. tablets (pink) and 0.2 mg. tablets (white), each in bottles of 40 tablets. Also in 0.4 mg. (2cc.) and 0.2 mg. (1cc.) ampuls, each in boxes of 6 ampuls, for intravenous use when the oral route cannot be employed.

Physicians are invited to send for clinical test sample and literature

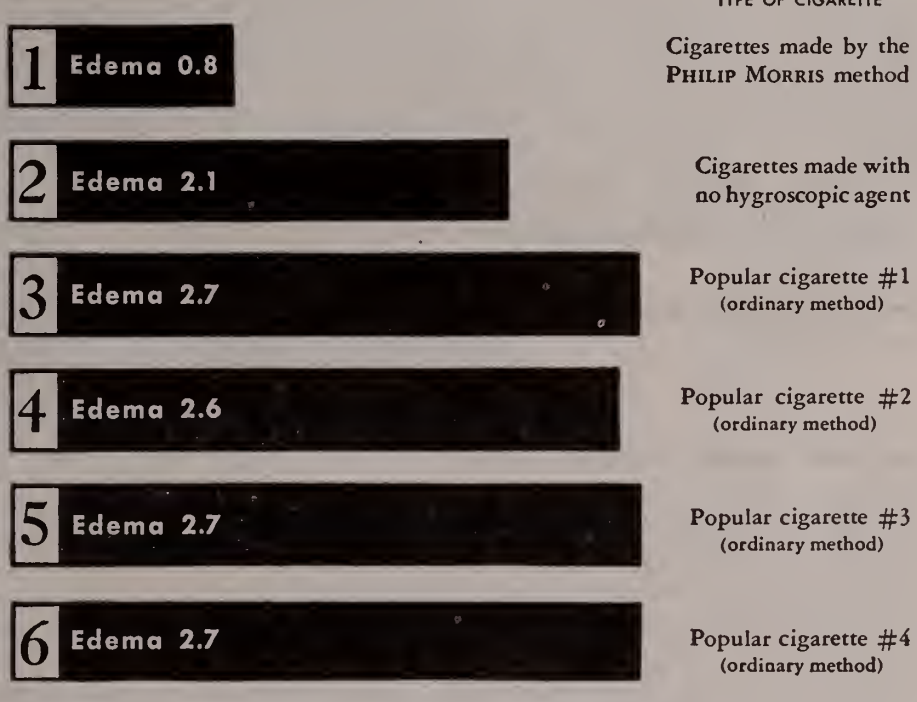
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Digitaline Nativelle
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THE ORIGINAL DIGITOXIN, IN PURE, CRYSTALLINE FORM

How irritation varies from *different* cigarettes

Tests made on rabbits' eyes reveal the influence of hygroscopic agents*



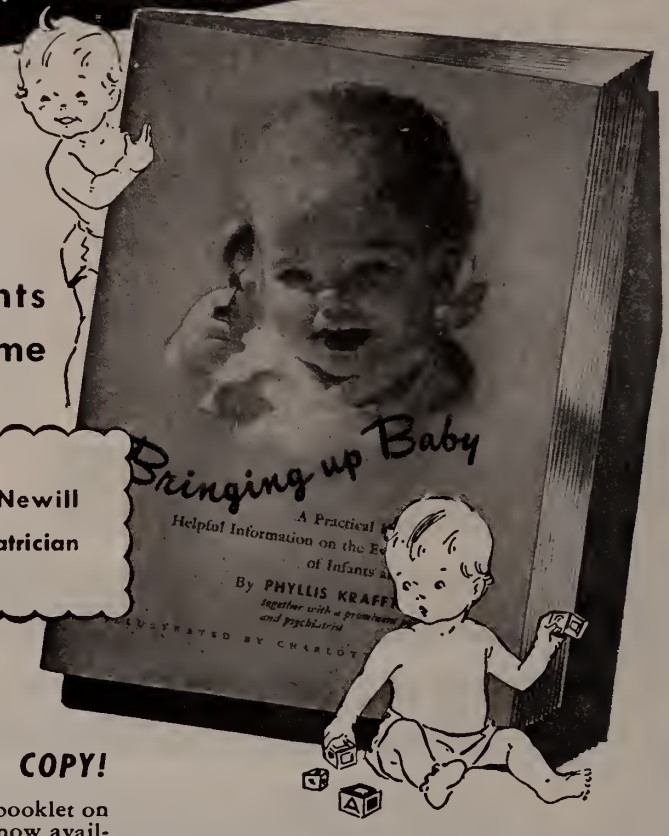
CONCLUSION:* Results show that regardless of blend of tobacco, flavoring materials, or method of manufacture, the irritation produced by all ordinary cigarettes is substantially the same, and measurably greater than that caused by PHILIP MORRIS.

CLINICAL CONFIRMATION:** When *smokers* changed to PHILIP MORRIS, substantially every case of irritation of the nose and throat due to smoking cleared completely or definitely improved.

N. Y. State Journ. Med. 35 No. 11,590* *Laryngoscope 1935, XLV, No. 2, 149-154*

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

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The only advertising matter in the booklet is some paragraphs on Quaker Enriched Farina —its value as a "first cereal"—its enrichment with Vitamin "D," 2 B-Vitamins, Calcium and Iron.

This time-tested cereal is milled to Quaker's high standards, the same standards that have made Quaker and Mother's Oats trusted names for four generations.

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MIGRAINE



"Emotional states, such as frustration, resentment, hostility and humiliation, associated with abrupt changes in the pace of living... together with physical fatigue, activate the migraine mechanism."*

*Simons, D. J., and Wolff, H. G. (The Management of Chronic Diseases of the Nervous System): M. Clin. N. Am., p. 434, March, 1944.

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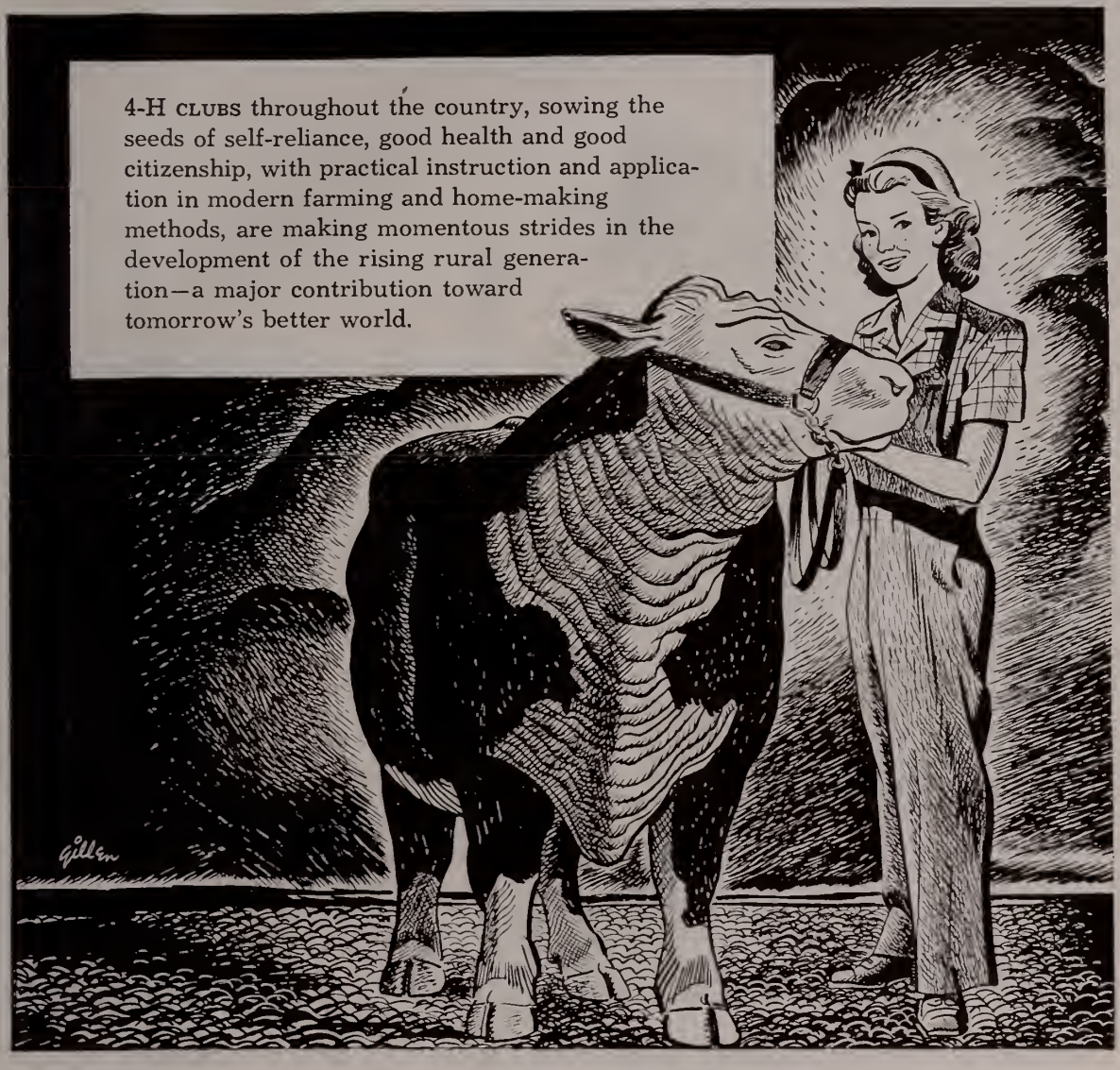
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1. Pilcher, Am. Jour. Pharm., 64:1, 1917.

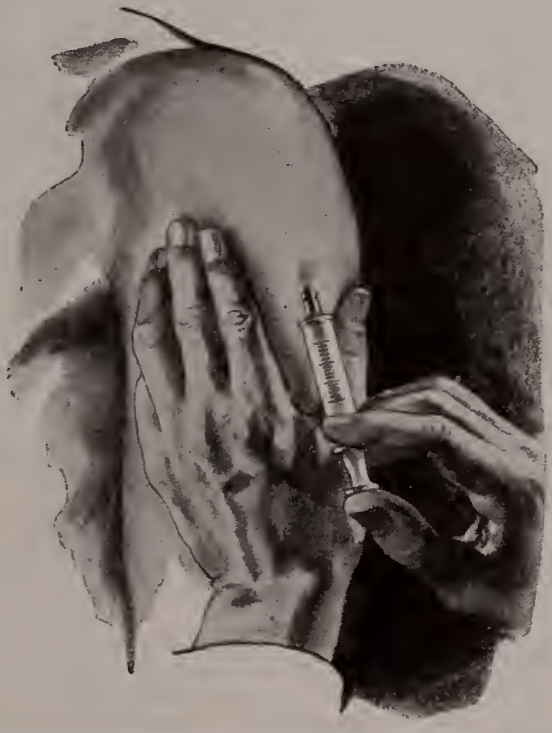
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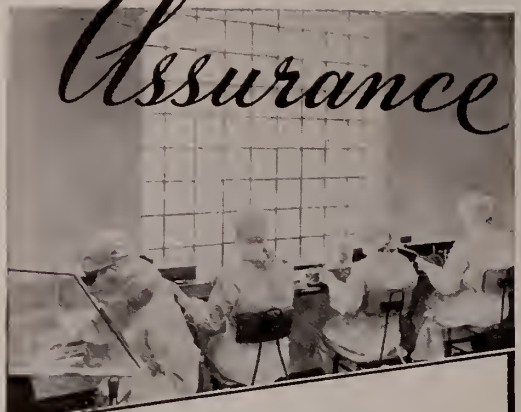
For oral administration, Bethiamin, crystalline thiamine hydrochloride, is available in capsules containing 1 mg., 3½ mg., 10 mg., and 15 mg.; for parenteral administration, in 1 cc. ampuls containing 1 mg., 10 mg., 50 mg., and 100 mg., and in 10, 30 or 60 cc. rubber-capped vials. In liquid form Bethiamin Elixir contains 6 mg. of thiamine hydrochloride per fluidounce.

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P. R. N.

The Jocular Jingles of C. G. F.

by

Charles G. Farnum M. D.
Peoria, Ill.

OUR YESTERDAYS

It matters little what the future holds,
Or what uncertain Fate may have in store,
Or what a coming day or year unfolds,
Because at most there can't be many more.

The past has been so long, so wholly filled
With joyous living! Now it brings relief
To sit and scan those years that fired and thrilled.
What matter if the future then is brief?

We think of fine, heroic souls we served,
Who bravely face most overwhelming odds,
Who lived and worked and died and all deserved
The benediction of immortal gods.

We contemplate how chance has changed life's plot,
The battles, waged and all too many lost.
Sometimes the human wreckage merits not
The agony and labor that it cost.

Religion and philosophy have failed
To clarify why younger folks should die,
Why aged ones with suff'ring are entailed—
A thousand times we ask the question, Why?

We meditate on distant places known,
On peoples met throughout the world's far ends,
Of varied speech and customs not our own;
But best of all is home and loyal friends.

Yes, life has been a long and gladsome trail,
Enough of mirth to dull the edge of grief,
Enough of play to keep from growing stale,
Absorbing work to make the years seem brief.

It matters little what the future holds,
Our heart is filled with joy and humble praise,
For we possess what all our past unfolds,
Fate cannot take away our yesterdays.

WORK

Where could I look for interest more than in my daily work?
'Tis vastly more intriguing than the things that we call play;

(*Continued on page* 54)



A reputation backs it

The reputation of one of the country's leading manufacturers of hormones assures the physician who prescribes "THYROID-SCHERING" of conformity to the rigid specifications of the U.S.P. XII.

THYROID *Schering*

THYROID-SCHERING is standardized by *chemical analysis* to contain 0.20 per cent of iodine in organic combination. This method is regarded as the most valid assay technique, and is the accepted procedure in all official preparations.

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P. R. N. (Continued)

My work, in contemplation,
Provides such fascination,
That I can fold my hand and sit and look at it all day.

PROCRASTINATION

"Procrastination is the thief of time" — Old Adage.

Procrastination sometimes proves a helpful friend
When work is piled before you mountain high;
The countless things you ought to do possess no end,
You cannot finish all, no matter how you try.

When conscience warns, "Get going or you'll rue it,"
Procrastination says, so suave, polite,
"Just put it off, you may not have to do it;"
And half the time we find that he is right.

Procrastination is so oft maligned, mistreated,
Is called the thief of time, a glaring sin;
If we defeat Procrastination we're defeated
For half the work we do need not have been.

Postpone all things you can until the morrow,
Tomorrow then procrastinate some more,
'Twill save you loads of work and grief and sorrow,
Tranquility and peace be at your door.

THE WORM TURNS

I am a patient humble
I'm rarely known to grumble
At indignities I suffer from my nurse.
They dress my wounds so painful
Give enemas so baneful
No matter what it is, it might be worse.

Nauseous doses bring the tears
Sticky soap is in my ears
Icy alcohol is rubbed upon my chest.
Crumbs of food are in my bed,
I've no choice in what I'm fed
But at trifles such as these I'd not protest.

But how I rage and sputter
And search for words to utter
The vehement protest surging through my head
'Tis rank insinuation
In fact an allegation
When they put a rubber sheet upon my bed.

Professor Paresis asserts that egotism is not so bad. For some of us it makes living with ourselves less unpleasant.



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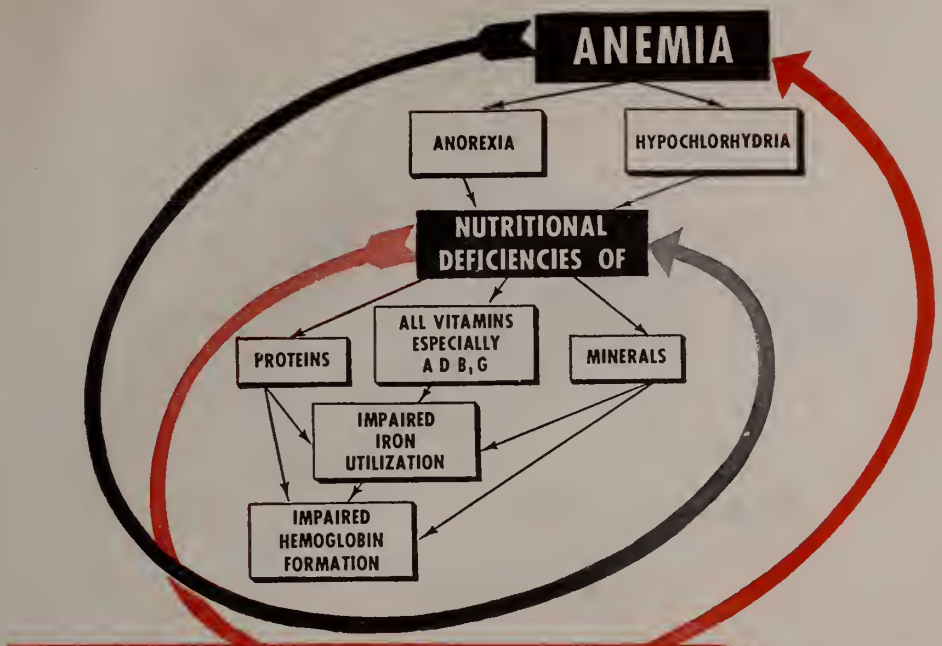
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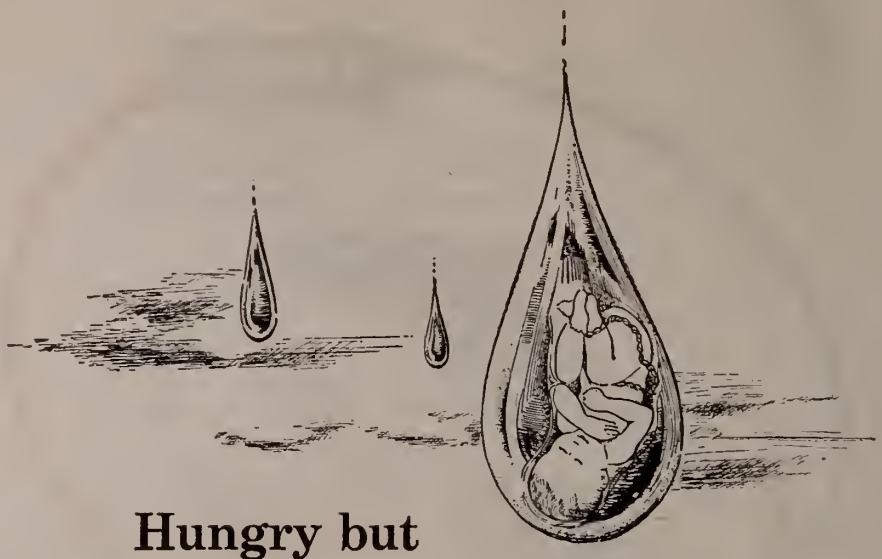
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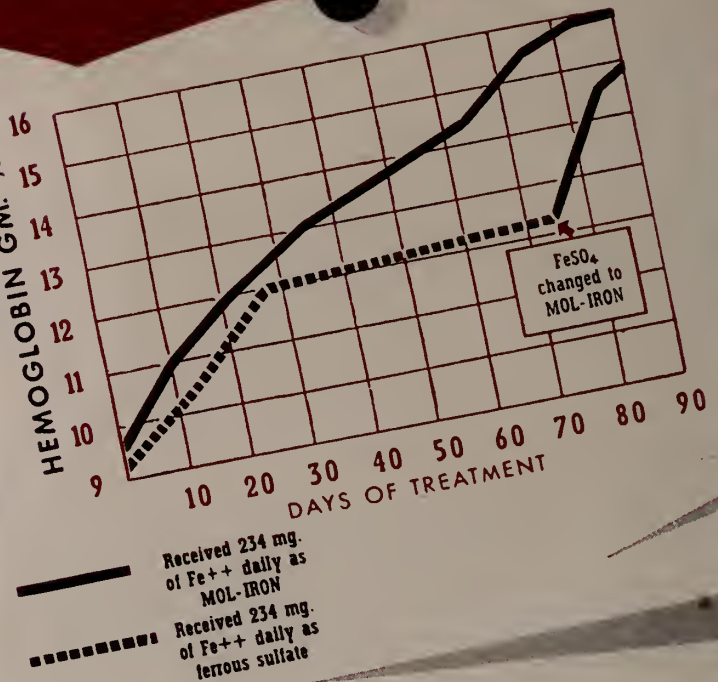
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Book Reviews

BRONCHIAL ASTHMA: By Leon Unger, B.S., M.D., F.A.C.P., Assistant Professor, Department of Medicine, Northwestern University Medical School, Chicago. Introduction by Morris Fishbein, M.D., Editor, Journal of the American Medical Association, 1945, Charles C. Thomas, Publishers, Springfield, Illinois. Price $9.00.

Doctor Unger, with many years' experience in the management of asthma in the course of an extensive practice in allergy, has had an unusual opportunity to study this important subject both from the standpoint of allergy and other recognized types of bronchial asthma. Doctor Unger started the allergy clinic at Northwestern University Medical School in 1924, and it has become one of the outstanding clinics of its type to be found anywhere.

The book is divided appropriately into three sections. The first is the clinical section; the second the laboratory section, then the appendix which covers a number of highly important subjects of interest to physicians who desire to help their patients suffering with bronchial asthma. After giving the reader a working knowledge of the terms used in allergy considerations, he tells an interesting story of the history of bronchial asthma, showing that it was known long before the Christian Era began, then step by step he tells of the increasing knowledge concerning the cause and treatment of this disease up to the present time.

The etiology is described in detail with many exciting factors considered under such headings as inhalants, ingestants, injections, contactants, drugs, and even vitamins are listed among these excitants. Likewise the sting of many insects have been shown to be exciting factors in some cases. The symptomatology and diagnosis are given consideration. The author has arranged an interesting table showing the differential points in consideration of bronchial asthma and cardiac asthma which will be of much interest to the reader.

The specific diagnosis with special reference to skin tests as well as specific and non-specific treatment are given careful and meticulous consideration as would be expected in a monograph on this subject. The management of atypical cases is likewise outlined in detail. Realizing the importance of this subject in war time, the author has devoted an unusually inter-

(*Continued on page 62*)

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BOOK REVIEWS (Continued)

esting chapter to the military aspects of bronchial asthma.

In the laboratory section Doctor Unger tells in detail of the preparation of extracts, technique of pollen and mold counts, and technique of estimation of leucopenic index. In the appendix he refers to the sources of allergans, information and special instructions for patients, instructions to avoid house dust, how to gather dust for extracting, elimination diets and food diaries, and discusses oral hyposensitization to foods.

The introduction was written by Morris Fishbein, and the book contains many interesting illustrations and tables which will add materially to its value. Physicians everywhere, regardless of their line of work, as well as students and others interested in this important subject, will find this book one which they will use freely and frequently in their daily routine. It should be in any modern medical library as a "MUST".

ESSENTIALS OF CLINICAL ALLERGY: By Samuel J. Taub, M.D., Professor of Medicine, Cook County Graduate School of Medicine. Attending Physician in Medicine, Cook County Hospital. Fellow of the American Academy of Allergy. Formerly Assistant Professor of Medicine, Rush Medical College, of the University of Chicago. Baltimore, The Williams and Wilkins Company, 1945. Price $3.00.

Many books have been written on the subject of allergy in recent years, and with the constantly increasing interest in the subject and the advances in knowledge concerning allergy, many modern texts on allergy are becoming quite voluminous, and contain much information that is still controversial.

The author in this volume has endeavored to stay away from the controversial subjects, and bring to the student and the physician in general practice such information on the subject as will bring him up to date, and make it possible for the general practitioners to readily acquire the necessary basic information to recognize many problems in allergy and be able to recommend the proper care of the allergic patients.

Recent knowledge on the subject leads the author to believe that perhaps 50% of the people have at some time had some manifestations of allergy, while perhaps 10% have had more serious forms requiring careful medical supervision. Giving as would be expected a careful and thorough discussion of hay fever and asthma, the author in much detail likewise describes the many types of allergy seen in the practice of medicine including several of the special fields.

The book was primarily designed as a ready reference on the subject with special emphasis on diagnosis and treatment, and the preparation of the materials used in treatment are likewise carefully discussed so that in the treatment of the usual case of allergy the general practitioner may handle the patient himself.

The method of preparing extracts is outlined in much detail, and will be of much interest to the

(*Continued on page 65*)

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BOOK REVIEWS (Continued)

average reader. This book of approximately 200 pages contains much information on a highly important subject in medicine, and one which the average practitioner of medicine will desire in the daily routine. Likewise it gives the essential information on an important branch of clinical medicine for the medical student who does not have time to go over the vast amount of literature on this subject which has appeared in recent years.

SYNOPSIS OF GENITOURINARY DISEASE: By Austin I. Dodson, M.D., F.A.C.S., Richmond, Virginia. Professor of Genitourinary Surgery, Medical College of Virginia; Genitourinary Surgeon to the Hospital Division, Medical College of Virginia; Genitourinary Surgeon to Crippled Children's Hospital; Urologist to St. Elizabeth's Hospital; Urologist to St. Luke's Hospital and McGuire Clinic. Fourth Edition. With 112 Illustrations. St. Louis, The C. V. Mosby Company, 1945. Price $3.50.

In this, the fourth edition of the Synopsis of Genitourinary Diseases, the author has added those important advances in chemotherapy and endocrinology, which have so materially changed the manner of treatment of many diseases of the genitourinary system. The book is intended to present a synopsis of genitourinary diseases for the student and for the physician in practice, and, of course, it is not intended for the specialist.

The book presents information concerning the etiology and pathology of diseases of the genitourinary system, the diagnostic procedures and with some information concerning treatment. A considerable amount of space is properly allocated to considerations of carcinoma of the prostate and the use of endocrine preparations in its treatment.

The indications for cystoscopy and other technical examinations are likewise given much consideration in the book. This book should be of inestimable value to the student as well as to the physician in practice desiring a ready reference on almost any subject pertaining to genito-urinary diseases.

(*Continued on page* 66)

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THE HERBAL OF RUFINUS. Edited from the Unique Manuscript by Lynn Thorndike, Professor of History at Columbia University. Assisted by Francis S. Benjamin, Jr., Instructor in Brooklyn College. Cloth. Price $5.00. Pp. 476. University of Chicago Press, Chicago, Illinois. 1945.

This publication of the thirteenth-century Latin work of Rufinus on herbs is the first printing from the only extant manuscript of it. Fully four-fifths of the volume deals with herb and vegetable products. Smaller parts of the text are devoted to animals and their products, minerals, compound medicines and a few such general topics as Qualitas, Rota and Zodiacus. There are chapters on unguents, waters and various mixtures set forth in chapters on a particular herb or drug which constitutes one of their ingredients. There is a discussion on diseases and physical ailments which offers a picture of public health and maladies prevalent in the thirteenth century. Mention is made of the effects of diseases or remedy on appetite, sleep, thirst, lust or such ills as asthma, arthritis, loss of hair, hemorrhoids, spots, the skin diseases, paralysis, heart trouble, nephritis, inflation and colic.

The careful, detailed descriptions of the stalk, leaves and flowers; the painstaking identification of different varieties of plants; and the careful checking of the many names often applied to a single plant are unusual features in the history of medieval botany. It is a great contribution to our knowledge of the history of botany and medicine and it should supply material for use in modern critical editions, when they are first attempted, of other celebrated authors.

For students of medieval Italian and other related vernaculars the Herbal offers valuable philological suggestions, not only in the names of herbs, but also in many instances of rare works. An English translation by the editors should be undertaken for a wider circulation and appreciation of this volume.

L. R. M.

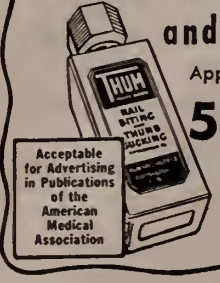
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BOOK REVIEWS (Continued)

on 762 figures. Philadelphia and London: W. B. Saunders, 1945. Price $10.00.

The fact this is the fourth edition of an ever-popular textbook on Surgery in a short period of nine years, speaks well for its place among texts on this ever-popular subject. Although edited by Doctor Christopher, more than 200 American authors participated in the preparation of the text covering every branch of surgery.

Many new sections are provided in this edition including one on Military Surgery by Col. Edward D. Churchhill, and one on Chemotherapy in Surgical Infections written by John S. Lockwood, Professor of Surgery at Yale University. Many other subjects, not considered in previous editions, appear in this revised and reset fourth edition.

The individual contributors to this volume were selected carefully on account of their outstanding ability in the subjects they have presented, and the fact that they too are teachers of years' experience makes the book of greater value as a modern textbook on surgery. The extensive table of contents and the arrangement of the text itself makes it extremely easy for the reader to promptly find any subject in which he is interested at the moment.

With 1548 pages and 1483 illustrations, the value of the book is considerably increased to the reader. The reviewer heartily recommends the fourth edition of Christopher's Textbook of Surgery, not only for the



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use of students, but also for the thousands throughout this country who must rely on their own ability and judgment in the consideration of surgical problems and frequently unassisted, on the emergency technic and aftercare of the surgical patient.

PLASTER OF PARIS TECHNIQUE in the Treatment of Fractures and Other Injuries. By T. B. Quigley, Lieutenant Colonel, Medical Corps, Army of the United States; Instructor in Surgery; Harvard Medical School (in absentia); Junior Associate in Surgery, Peter Bent Brigham Hospital, Boston (in absentia). The Macmillan Company, New York, 1945. Price $3.50.

Plaster of paris, being one preparation almost always available in the treatment of fractures, can be used for most parts of the human body and like a tailored suit, is made to fit the individual requirements of the moment.

The author, having had an unusual opportunity to use plaster in the treatment of fractures and for immobilization in other injuries, gives freely of his knowledge in the book, so that the skill required to properly use this material may be readily acquired. The author states that the construction of plaster casts is a craft rather than an art, and one which may be acquired by those of reasonable intelligence and with a medium of manual dexterity.

The author does not discuss the choice of treatment

(*Continued on page* 70)

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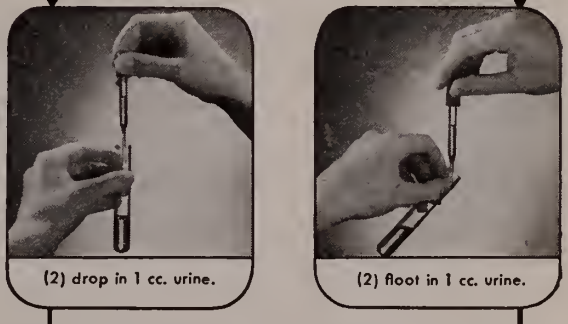
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BOOK REVIEWS (Continued)

in the book, and only a slight reference is made to actual indications for treatment other than to show the proper methods of applying plaster in the various types of fractures and injuries.

The book is divided into four chapters dealing with general considerations, the upper extremity, the lower extremity and the vertebral column. The application of plaster in the various types of fractures encountered in these respective areas are well described in the text. More than 100 illustrations greatly increase the value of the book to the reader, and this book should be of great interest to the thousands of physicians who are required to care for fractures and other types of injuries in their practice, requiring immobilization.

Books Received

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

SYNOPSIS OF THE DIAGNOSIS OF THE SURGICAL DISEASES OF THE ABDOMEN; Second Edition; By John A. Hardy, B.Sc., M.D., F.A.C.S., El Paso, Texas; 100 illustrations; The C. V. Mosby Company, St. Louis, Missouri, 1945; Price $5.00.

THE ART AND SCIENCE OF NUTRITION; Second Editon; By Estelle E. Hawley, Ph.D. and Grace Carden, B.S., The University of Rochester, School of Medicine and Dentistry, Strong Memorial and Rochester Municipal Hospitals, Rochester, N. Y.; 139 illustrations, including 11 in color; The C. V. Mosby Company, St. Louis, Missouri, 1944; Price $3.75.



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